



**WORKERS COMPENSATION CLAIM (FORM 122)**

This form must be filled out completely.  
Additional space is provided at the end, if needed.

EMPLOYEE NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DRIVER LICENSE # \_\_\_\_\_ ISSUING STATE \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ # DEPENDENTS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ JOB TITLE \_\_\_\_\_

DEPARTMENT \_\_\_\_\_ SUPERVISOR NAME \_\_\_\_\_ PHONE \_\_\_\_\_

# OF DAYS WORKED PER WEEK \_\_\_\_\_ # OF HOURS WORKED PER WEEK \_\_\_\_\_ LAST DAY WORKED \_\_\_\_\_

DATE OF ACCIDENT \_\_\_\_\_ TIME OF ACCIDENT \_\_\_\_\_ TIME BEGAN WORK \_\_\_\_\_

DATE EMPLOYER NOTIFIED \_\_\_\_\_ WHO DID YOU NOTIFY \_\_\_\_\_ TIME \_\_\_\_\_

IF NOTIFICATION OR REPORT WAS DELAYED, DESCRIBE THE REASON \_\_\_\_\_

\_\_\_\_\_

LOCATION AND ADDRESS WHERE ACCIDENT OCCURRED \_\_\_\_\_

\_\_\_\_\_

**SPECIFICALLY DESCRIBE THE ACCIDENT:** Additional space available at the end of the report.

HOW DID THE ACCIDENT OCCUR \_\_\_\_\_

\_\_\_\_\_

DESCRIBE THE WORK BEING PERFORMED \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WAS THIS YOUR REGULAR DUTY \_\_\_\_\_ IF NO, WERE YOU TRAINED FOR THIS AND BY WHOM? \_\_\_\_\_

\_\_\_\_\_

WAS SAFETY EQUIPMENT PROVIDED \_\_\_\_\_ WHAT WAS THE SAFETY EQUIPMENT \_\_\_\_\_

\_\_\_\_\_

WAS IT USED \_\_\_\_\_ IF NO, EXPLAIN WHY? \_\_\_\_\_

\_\_\_\_\_

WHO WAS INVOLVED \_\_\_\_\_

\_\_\_\_\_

WEATHER CONDITIONS \_\_\_\_\_ ROAD CONDITIONS \_\_\_\_\_ SPEED \_\_\_\_\_

DESCRIBE IN DETAIL, THE DAMAGE DONE TO COUNTY PROPERTY/EQUIPMENT/VEHICLE

\_\_\_\_\_

\_\_\_\_\_

WAS A POLICE REPORT TAKEN \_\_\_\_\_ WHICH AGENCY \_\_\_\_\_ NAME OF OFFICER \_\_\_\_\_  
 COUNTY VEHICLE OR EQUIPMENT BEING OPERATED \_\_\_\_\_ EQUIPMENT # \_\_\_\_\_  
 LICENSE PLATE # \_\_\_\_\_ VIN # \_\_\_\_\_

**EMPLOYEE INJURY**

NO INJURY \_\_\_\_\_

SPECIFICALLY DESCRIBE THE INJURY IN YOUR OWN WORDS AND ALSO MARK THE BOXES COORESPONDING TO THE INJURY

PART OF BODY		TYPE OF INJURY/EXPOSURES	CAUSE
____ HEAD	____ WRIST	____ PICTURE WOUND	____ FALL
____ EYES	____ HAND	____ FOREIGN BODY	____ SLIP
____ NOSE	____ FINGER	____ SPRAIN/STRAIN	____ SPILL-SPRAY
____ MOUTH	____ HIP	____ HERNIA	____ STRUCK BY PERSON
____ EAR	____ THIGH	____ LACERATION	____ STRUCK BY EQUIP.
____ NECK	____ KNEE	____ FRACTURE	____ STRUCK BY OBJECT
____ LEG	____ SHOULDER	____ DISLOCATION	____ PULLING/PUSHING
____ ANKLE	____ BACK, UPPER	____ INFECTIOUS DISEASE	____ LIFTING
____ FOOT	____ BACK, LOWER	____ BURN/SCALD	____ BENDING/REACHING
____ CHEST	____ TOES	____ IRRITATIONS	____ EXPOSURE
____ ARMS	____ INTERNAL	____ RESPIRATORY	____ OVEREXERTION
INDICATE	LEFT ____ OR RIGHT ____	____ OTHER	____ OTHER

**MEDICAL TREATMENT** – NAME, ADDRESS & PHONE OF PHYSICIAN

- NO TREATMENT
- MINOR TREATMENT BY EMPLOYER \_\_\_\_\_
- TREATMENT BY PRIVATE PHYSICIAN \_\_\_\_\_
- EMERGENCY CARE – Rescue and/or Hospital \_\_\_\_\_
- HOSPITALIZED MORE THAN 24 HOURS \_\_\_\_\_
- MAJOR MEDICAL \_\_\_\_\_

**OTHER VEHICLE AND/OR PROPERTY**

NAME OF OWNER \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

NAME OF DRIVER \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

VEHICLE PLATE # \_\_\_\_\_ VIN# \_\_\_\_\_ MAKE & MODEL \_\_\_\_\_

DAMAGED PROPERTY \_\_\_\_\_

**SECOND PARTY INJURY: DESCRIBE THE INJURY TO THE OTHER PERSON(S) TO THE BEST OF YOUR KNOWLEDGE**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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**WITNESS(ES):**

WITNESS NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

WITNESS NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

**ADDITIONAL EMPLOYEE COMMENTS**

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**SUPERVISOR COMMENTS**

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**SAFETY COORDINATOR COMMENTS**

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EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SUPERVISOR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

H.R DEPARTMENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SAFETY COOR. SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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**HUMAN RESOURCE DEPARTMENT ONLY**

STATE OF HIRE \_\_\_\_\_ DATE HIRED \_\_\_\_\_ EMPLOYMENT STATUS \_\_\_\_\_

RATE OF PAY \_\_\_\_\_ DATE RETURNED TO WORK \_\_\_\_\_

DATE REPORT FILED WITH Traveler's \_\_\_\_\_ NAME OF OPERATOR \_\_\_\_\_