Claim No. _____

To enable the Company to give your case prompt attention in accordance with the compensation law, please complete this form in full and return it immediately in the enclosed envelope which requires no postage stamp.

Employee's Injury Report

Name of Employer	How long have you worked for this employer?		
Are you living in your employer's household or premises?	If related to employer, state relationship		
Occupation when injured?	Were you doing your regular work?		
On whose payroll when injured?	Wages when injured (per day, per week)	Work days per week	
Were you a temporary or steady employee?	Age	Are you married?	
No. of children and age of each			
If under 21 years, give name and address of your parent or guardian			
Date of injury (hour)	Date you were forced to leave work because of your injury (hour)		
Place where injury was sustained (No.,Street, City or Town)	Were you on employer's premises?		
Was injury caused by another person?	Name of other person		
Who is he employed by?			
Have you claimed or received settlement for this injury?	From whom?		
Name and address of two eye witnesses			
When did you first report your injury?	To whom did you first report your injury?		
Name of your doctor	Doctor's address		
Have you returned to work?	If so, what date?		
Describe your injury and how accident happened?			
Date of this report	Signature		
Address (No.,Street,City or Town)	Telephone Number		