pharmacists mutual
TOMORROW. IMAGINE THAT.

NOTIFICATION OF WORKERS' COMPENSATION CLAIM

Please send this completed form to workcomp@phmic.com or fax to 562-506-0306.
Please fill out this paperwork as completely as possible.

EMPLOYER

INSURED NAME | FEDERAL TAX ID | LOCATION # | POLICY #
ADDRESS | UNEMPLOYMENT ID | D/B/A NAME
CITY STATE ZIP | SIC/NAICS CODE | ADDRESS
COUNTY PHONE | CITY STATE ZIP

EMPLOYEE

FIRST NAME MIDDLE NAME LAST NAME | EMPLOYEE NUMBER | SSN | PHONE NO.
ADDRESS | DATE OF BIRTH ☐ MALE ☐ FEMALE | MARITAL STATUS | # DEPENDENTS
CITY STATE ZIP | OFFICER / PARTNER ☐ YES ☐ NO | DATE OF HIRE | STATE OF HIRE | MINOR'S WORK CERTIFICATE NUMBER (IF UNDER 18)
COUNTY

REGULAR DEPARTMENT OR DIVISION No. NAME | OCCUPATION | NCCI CLASS CODE

WAGE RATE PER | AVERAGE HOURS/DAY | AVERAGE DAYS/WEEK

OCCURRENCE

PLACE OF ACCIDENT OR OCCURRENCE | DATE OF INJURY / ILLNESS | DID EMPLOYEE LOSE ONE OR MORE DAYS OF WORK? ☐ YES
CITY STATE ZIP | TIME OF OCCURRENCE | LAST DATE WORKED
COUNTY OF INJURY FILING STATE | TIME WORKDAY BEGAN | FIRST DATE OF DISABILITY
FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO ☐ N/A
DID SALARY CONTINUE? ☐ YES ☐ NO ☐ N/A
EMPLOYER'S PREMISES? ☐ YES ☐ NO ☐ UNKNOWN | ☐ NO ☐ UNKNOWN

RETURNED TO WORK? ☐ YES: DATE ☐ NO ☐ UNKNOWN | DATE EMPLOYER NOTIFIED PERSON NOTIFIED

DESCRIBE NATURE OF INJURY OR ILLNESS IN DETAIL (Include part of body affected, e.g., strain to lower back, fractured arm, lead poisoning.)

EMPLOYEE'S WORK ACTIVITY AT TIME OF INJURY (e.g., loading truck, typing, assembling product)

DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURRED WITH DETAILS OF HOW EVENT OCCURRED (Who was involved, tools, machinery, employee's actions, etc.)

FATALITY? ☐ YES ☐ NO
DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO ☐ N/A
WERE THEY USED? ☐ YES ☐ NO ☐ N/A

MEDICAL INFORMATION

SELECT TYPE OF TREATMENT
☐ NO MEDICAL TREATMENT
☐ HOSPITALIZED
☐ OUTPATIENT
☐ EMERGENCY ROOM
☐ IN-HOUSE / FIRST AID
☐ UNKNOWN

FACILITY NAME | TELEPHONE
ADDRESS | PHYSICIAN'S NAME
CITY STATE ZIP

WITNESSES (NAME & PHONE NO.)

DATE COMPLETED	REPORTED BY/CALLER	TITLE	PHONE NUMBER AND EXT.	EMAIL