

Submission Date:

EMPLOYEE INFORMATION					
Employee Name (First & Last)			Gender	Hired Date	Hired in NH
Employee ID		Date of Birth	Age	Occupation when Injured	
Employee Address	Telephone	Wages per Hour	Hrs per Day	Days per Week	Average Weekly Earnings

INJURY INFORMATION			
Injury Date / Time	Date Employer Notified of Injury	Location/Jobsite & Business Name where accident occurred	
Disability Began Date			
Claim Type	Full Wages Paid on Injury Date		
Accident Description			
Body part Injured		Cause of Injury	
Nature of Injury		Witness Name	Witness Phone
Has injured returned to work?	If so, what date?	If so, at what occupation?	If so, at what duty status?
Initial Treatment			
Initial Treatment Comments			
Name of Treating Physician		Name of Treating Hospital	Has injured died? If so, what date

EMPLOYER INFORMATION			
Employer Name		Employer FEIN	Industry Code
Employer Contact Name	Contact Phone Number	Employer Business Address	
Managed Care Provider			
Leased Employee? Client Company			
		OCIP/Wrap-Up Policy? Name of policy holder	

INSURER INFORMATION			
Insurance Carrier	Insurer Type	Policy Number	Telephone Number

SUBMITTER INFORMATION			
Submitter Name	Title of Submitter	Represents	Telephone Number