WORKER'S COMPENSATION REPORT

DO NOT File This Form With
The Department of
Industrial Accidents

Form 118-MedFax Rev.2 8/03

Employee Name (Last, First, MI):	Employee Telephone: ( ) -	Social Security Number: -- --
Employee Address:	Sex: ( )F ( ) M	Date of Birth: / /
Insurance Carrier:		Marital Status: ( ) Single ( ) Married
Employer:	Employer Telephone: ( ) -	Policy Number:
Employee Occupation:	Date of Incident: / /	Time of Incident: ( ) AM ( ) PM
Date of Hire: / / — Date Incident Reported: / /	To Whom:	Returned to work: ( ) Yes ( ) No
Address where injury occurred:	Date of Return to Work: / /	Returned to Regular Job: ( ) Yes ( ) No
Type of injury (Burn, Fracture, Cut, Etc.)	Average 52 Week Wage: $ ______	( ) Estimated ( ) Actual
Injured Body Part(s): (Arm, Leg, Back, etc.):	Source of Injury (Chemicals,	Machinery, etc.):
Described What Happened:		
Supervisor Signature: ______		**Date:** ____/____/____

Medical Authorization: In accordance with state law, I , the undersigned, authorize A.I.G., as a workers compensation insurer, and its authorized agents or representatives, as well as my employer to be furnished with any information or facts regarding this injury only, including records, diagnosis, medical treatment and prognosis, estimates of disability and recommendations for further treatment. This information is to be used for the sole purpose of evaluating and handling my claim and to assure timely medical care as a result of the incident occurring on or about the above noted date and for no other purpose, now or in the future. I also agree that a photocopy of this release is as valid as the original.

Employee Signature: ______________________________ **Date:** ____/____/____

I do not want medical treatment for this injury –

Employee Signature: ______________________________ **Date:** ____/____/____