ACCIDENT/INCIDENT REPORT FORM

Date of incident: _____ Time: _____ AM/PM

Name of injured person: _____

Address: _____

Phone Number(s):_____

Date of birth: _____ Male _____ Female _____

Who was injured person? (Circle one) Passenger System Employee

Type of injury: _____

Details of incident: _____

_____

_____

_____

_____

Injury requires physician/hospital visit? Yes ___ No _____

Name of physician/hospital: _____

Address: _____

Physician/hospital phone number: _____

Signature of injured party

_____

Date

*No medical attention was desired and/or required.

_____

Signature of injured party Date

Return this form to City Clerk's Office within 24 hours of incident.

City Clerk's Office* 128 East Jefferson St., Yazoo City, MS 39194* 662-746-1401* cityclerk@yazoocityms.us

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filing.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F ☐ M ☐
3. Social Security Number - -	4. Home Phone ( )	5. Date of Birth (m-d-y) - -
6. Does the Employee Speak English? If No, Specify Language YES ☐ NO ☐		
7. Race White ☐ Black ☐ Asian ☐	8. Ethnicity Hispanic ☐ Native American ☐ Other ☐	
9. Mailing Address Street or P.O. Box		
City State Zip Code County		
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐		
11. Number of Dependent Children	12. Spouse's Name	
13. Doctor's Name		
14. Doctor's Mailing Address (Street or P.O. Box)		
City State Zip Code		

15. Date of Injury (m-d-y) - -	16. Time of Injury : am ☐ pm ☐	17. Date Lost Time Began (m-d-y) - -	
18. Nature of injury*	19. Part of Body Injured or Exposed*		
20. How and Why Injury/Illness Occurred*			
21. Was employee doing his regular job? YES ☐ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.)*		
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site Street or P.O. Box County City State Zip Code			
24. Cause of Injury (fall, tool, machine, etc.)*			
25. List Witnesses			
26. Return to work date/or expected (m-d-y) - -	27. Did employee die? YES ☐ NO ☐	28. Supervisor's Name	29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y)	31. Was employee hired or recruited in Texas? YES ☐ NO ☐	32. Length of Service in Current Position Months ___ Years ___	33. Length of Service in Occupation Months ___ Years ___
34. Employee Payroll Classification Code	35. Occupation of Injured Worker		
36. Rate of Pay at this Job $ _____Hourly $ _____Weekly	37. Full Work Week is: _____Hours _____Days	38. Last Paycheck was: $_____ for _____ Hours or ____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form Kaneilia Williams		41. Name of Business City of Yazoo City	
42. Business Mailing Address and Telephone Number Street or P.O. Box 128 Jefferson St Telephone (662-746-1401		43. Business Location (If different from mailing address) Number and Street	
City Yazoo City	State MS	Zip Code 39194	City State Zip Code
44. Federal Tax Identification Number 64-6001264	45. Primary North American Industry Classification Syste Code: (6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company BitCo Insurance Company		49. Policy Number WC 3 686 325	
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐			
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X_____ Date _____			