TANDEM HR
A Vensure Employer Solutions Company

Employee Accident/Injury Report

Company:	**Supervisor:**
Employee name:	**Job title:**
Phone:	**Address:**
SSN:	**Date of birth:**
Scheduled work hours:	**Location of injury:**
Date of injury:	**Time of injury:**

Describe what happened:

Describe the injury:

List all witnesses to the accident/injury including name and company.

Did you refuse treatment? ☐ **Yes** ☐ **No**	**If yes, why?**
Place of treatment (name and address:	
Name of treating doctor:	
Type of treatment:	
Have you been treated for this condition before?	

Your employer will make available Modified Duty when possible. If you have been released to return to work modified duty or full duty, you (the employee) are required to inform your supervisor within 24 hours.

_____ _____
Employee signature Supervisor signature

_____ _____
Date Date

Please send completed forms to wcnewclaims@Vensure.com.

TANDEM HR
A Vensure Employer Solutions Company

Supervisor Accident/Injury Report

Forward completed form to Human Resources. This form must be completed and returned within 24 hours of the accident/injury. *There are no exceptions to this rule.*

Company:	**Supervisor:**
Branch/office location:	
Injured employee:	**Job title:**
Scheduled work hours:	**Location of injury:**
Date of injury:	**Time of injury:**

List all witnesses to the accident/injury including name, company, and phone number.

Injury details including the nature and extent of the injury (including body parts involved) and the specific circumstances under which the injury occurred in relation to job duties. Please be as detailed as possible.

Employee refuse treatment? ☐ **Yes** ☐ **No**	**If yes, why?**
Who transported the employee?	**Type of transportation:**
Place of treatment (name and address):	
Date of treatment:	**Treating doctor:**
Type of treatment:	

Will the employee be able to return to work? ☐ **Yes** ☐ **No**

Will the employee be limited to light work? ☐ **Yes** ☐ **No**

Will the employee lose time from work? ☐ **Yes** ☐ **No** **If yes, how long?**

Estimated return to work date:

_____ _____
Supervisor signature Date

_____ _____
Reviewed by Date

This form will be maintained in the Human Resources files.

Please send completed forms to wcnewclaims@Vensure.com.

TANDEM HR
A Vensure Employer Solutions Company

For Human Resources use ONLY

Date of hire:	**Hourly wage:**
Address:	
Phone:	
Date of birth:	**SSN:**

Please send completed forms to wcnewclaims@Vensure.com.

TANDEM HR
A Vensure Employer Solutions Company

Accident/Injury Witness Form

Please give us your contact details.

Name:	**Phone:**
Address:	

Did you see the accident? ☐ **Yes** ☐ **No**

Date of accident:		**Time of accident:**
Location of accident:		
Where were you?		
Was anyone injured?	☐ **Yes** ☐ **No**	**If yes, who?**
Are you of relation to anyone involved?	☐ **Yes** ☐ **No**	**If yes, who?**
Names of other known witnesses:		

Please describe what happened with as many details as possible.

_____ _____

Witness signature **Date**

Please send completed forms to wcnewclaims@Vensure.com.