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

Submit completed forms to wcnewclaims@Vensure.com.