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| **TO BE COMPLETED BY EMPLOYEE** |
| First Name:  | Last Name:  |
| Date of Birth: | Phone Number: |
| Date of Accident: | Time of Accident: |
| Where did the incident occur?  |
| Nature of Injury: (e.g., cut, sprain, bruise, etc.) |
| Body Part Affected: (e.g., arm, leg, back, etc.) |
| Immediate Treatment Provided: (Describe any first aid or treatment administered on-site.) |
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| Employee’s Statement (Describe what you were doing and how the accident occurs, what injury resulted?): |
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| Employee’s Signature:  | Date:  |

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| **TO BE COMPLETED BY SUPERVISOR** |
| First Name:  | Last Name:  |
| Date/Time Supervisor Notified:  |
| Where did the incident occur?  |
| Nature of Injury: (e.g., cut, sprain, bruise, etc.) |
| Body Part Affected: (e.g., arm, leg, back, etc.) |
| Immediate Treatment Provided: (Describe any first aid or treatment administered on-site.) |
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| Has employee returned to work? ☐ Yes ☐ No |
| Supervisor’s Statement (Describe what you witnessed and how the accident occurs, what injury resulted?):  |
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| Supervisor’s Signature:  | Date:  |

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| **TO BE COMPLETED BY HUMAN RESOURCES** |
| Claim Number:  | Date Reported Processed:  |

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| **BILLING INSTRUCTIONS** |
| Please send all bills to: Please include claim number, Claimant Name and Date of Loss/Injury in all correspondence. AmTrust North America Inc.  P.O. Box 5876 Cleveland, OH  44101AmTrustClaims@AmTrustGroup.com |