REPORT ALL WORKER'S COMPENSATION INJURIES TO LIBERTY MUTUAL INSURANCE
The 1-800 CLAIMS SERVICE CENTER is open 24 hours a day including Weekends and Holidays. For efficient service, have the following information available for the Customer Service Representative.

Call: 1-800-362-0000

ExPRSCall W C Report Form

CLAIM INFORMATION

Date/Time of Injury: / / : am pm

After the call, write claim number here: **WC**

Is this claim work related? Yes O No O

Will the employee miss time from work? Yes O No O

Employer Name:

EMPLOYEE INFORMATION

Employee's Social Security Number: - -

Employee's Name:

Home Address: (Street) (City) (State) (Zip)

Home Phone Number: ( ) -

Male O Female O

Date of Birth:

Marital Status (circle one) Single Married Widowed Divorced

Hire Date:

Number of Dependents: Dependents Under 18:

Occupation:

Department Name:

State Hired:

Supervisor Name & Phone:

Current Weekly Wage:

Hourly Wage:

Hours Worked Per Week:

Days Worked Per Week:

Hours Worked Per Day:

Employment Status:

Employer Report No:

Employee ID No:

Was Salary Continued:

Was Employee Paid in Full for Date of Injury:

How often is employee paid:

Education Level:

Any Prior WC Injuries:

OSHA Reference No.:

EMPLOYER INFORMATION

Contact Name, Telephone Number, and Title:

Work Location: (Street) (City) (State) (Zip)

Mailing Addr: (Street) (City) (State) (Zip)

Employer Location Code:

Employer SIC.:

Employer FED ID.:

Employer Code:

Nature of Business:

Policy Number:

ACCIDENT INFORMATION

Did the Accident Occur at the Work Location? Yes O No O If no, where did the accident occur?

Accident Address: (Street) (City) (State) (Zip)

Nature of Accident:

Give a Full Description of the Accident: (Be As Complete As Possible)

Are Other WC Claims Involved? Yes O No O

Date and Time Reported to Employer: : AM PM

Person Reported To:

CONTINUED ON REVERSE SIDE

INJURY INFORMATION

Injury Description:

Date of Death *(If applicable):* ▌ ▌	Is Employee Hospitalized? Yes O No O
Lost Time? Yes O No O	If yes, What was First Full Day Out: ▌ ▌
Date Last Day Worked: ▌ ▌	Date Disability Began: ▌ ▌
Date Returned to Work: ▌ ▌	**OR** Estimated Return to Work Date: ▌ ▌

Time Workday Began: : AM PM

Which Part of the Body Was Injured? (e.g. Head, Neck, Arm, Leg)	Nature of Injury: (e.g. Laceration, Bruise, Fracture)
Part of Body Location: (e.g. Left, Right, Upper, Lower)	Source of Injury:

MEDICAL INFORMATION

Safeguards Provided? Yes O No O	Safeguards Utilized? Yes O No O

Initial Medical Treatment: Circle One ER Treated and Released Hospitalized Physician/Clinic Minor/Onsite No Medical Treatment

Hospital - Name, Address, Phone, Fax:

Clinic/Doctor - Name, Address, Phone, Fax, Specialty:

WITNESS INFORMATION

Were There Any Witnesses? Yes O No O

If Yes, List Names and How to Contact Them:

ADDITIONAL COMMENTS & INFORMATION

REPORT PREPARED BY

Name: Title:

Signature: Phone: ( ) -