CoreMEDICAL GROUP
The Best in Healthcare Staffing

Incident Report - Employee Statement

All Claims Must be Reported Within 24 Hours of Occurrence!
Any Injured Employee Should Seek Medical Treatment as He/She Feels Necessary

EMPLOYEE INFORMATION

Employee SSN	First Name	Last Name
Current Mailing Address	City, State, Zip	Marital Status
Current Phone Number	Date of Birth	☐Male ☐Female Gender
Title	Unit	Full-Time or Part Time

INCIDENT DETAIL

Date Of Injury	Time Of Injury	
Date and Time CMG was Notified	Who did you notify?	How did you contact *Core*? Email, phone, text?
Start Time on the Day of Injury	Normal Scheduled Hours on Date of Injury	☐ Yes ☐No Did you complete your shift?
Location of Incident/Unit/Floor	Witness	Witness Phone Number

Was this incident reported to anyone at the facility? If so, whom?

Accident Description

2 Keewaydin Drive, Salem, NH 03079 Voice: 603-893-4515 800-995-2673 Fax: 603-893-8442

Automobile Accidents Only
Has this accident been file with your Auto-Insurance Carrier? ☐Yes ☐No
If not, will you be filing a claim with your Auto Insurance Carrier? ☐Yes ☐No
Please provide Auto-Insurance Carrier and Policy Number.

Injured Body Part/Location - Please be specific (right hand, ring finger)

Were safety devices in place? Please describe.

INITIAL MEDICAL TREATMENT

Medical Facility Name	Medical Facility Address	City, State, Zip
Physician Name	Medical Facility Phone Number	Medical Facility Fax Number
☐Yes ☐No Any Loss of Time?	If yes, number of days and/or hours?	
Last day present at work?	Date returned to work?	
Employee Signature	Date	

Please fax complete forms to *Core* at 866-420-1055 – Attn: Human Resources