MUNICIPAL EMPLOYEE'S REPORT OF ACCIDENT

mail to: Municipal League Workers' Compensation Trust P.O. Box 37

North Little Rock, AR 72115

To be completed by employee:

PERSONAL: Name	Eiret	Middle	Phone #	Bir	th Date
Address:					
EDUCATION: Circle highest grad	e level completed.	12345678	High School	19 10 11 12	College 1 2 3 4
Vocational Tech					
EMPLOYMENT: Present Employe					
Length of Employment	If less than 5 ye	ears with preser	nt employer, li	st employers	of past 5 years:
		D.I.			
ACCIDENT: Date of Accident					
Describe fully how accident happen	ned				
Who did you report this accident to	o?			When?	
Who witnessed the accident?					
Who is your supervisor?					
INJURY: Nature and location of in	jury (describe par	t(s) of body			
Name and Address of Doctor(s)					
Who selected Your Doctor?			Date of First	Visit	
1st day unable to work?	Are you still u	nder doctor's tr	eatment'?		
DISABILITY: How long does your	· doctor anticipate	you will be offs			
Are your wages continuing?	If so, fr	om what source	e?		
Regular wages,	Sick Le	ave,	Vacati	ion	
Have you ever collected compensat					
If yes, give details					
Have you ever had any other condition	ion or injury invol	ving this part of	your body pri	ior to this inj	ury? () yes () no
If yes, give details					
Name and Address of Family Physi	cian				
I, received this day, a	copy (front and b	ack) of the Ark	ansas Workers	s' Compensa	tion Form AR-N.
Employee Signature		Date			
Witness		Witness			