

EMPLOYEE INCIDENT/INJURY REPORT

THIS IS NOT A REPORT OF INJURY FORM. PLEASE REPORT THE INJURY ONLINE AT MEM-INS.COM OR BY CALLING 1.800.442.0593.

TO BE COMPLETED BY EMPLOYER	NAME OF INJURED EMPLOYEE		DATE OF INCIDENT	TIME OF INCIDENT _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	DATE REPORTED
	DEPARTMENT			JOB TITLE	HIRE DATE
	JOB PERFORMED			SUPERVISOR	
	EMPLOYER			MEM POLICY No.	
	EMPLOYER CONTACT NAME			EMPLOYER TELEPHONE NUMBER	
	INCIDENT LOCATION				
TO BE COMPLETED BY INJURED EMPLOYEE IF POSSIBLE	EXTENT OF INJURY <input type="checkbox"/> NO INJURY <input type="checkbox"/> FIRST AID ONLY <input type="checkbox"/> TAKEN TO CLINIC <input type="checkbox"/> TAKEN TO ER <input type="checkbox"/> FATALITY			TREATING MEDICAL FACILITY	
	BODY PART INJURED				
	DESCRIPTION OF INCIDENT				
ANY OTHER WITNESSES? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME AND PHONE No.	NAME AND PHONE No.	NAME AND PHONE No.	
WERE THERE OTHERS INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME AND PHONE No.	NAME AND PHONE No.	NAME AND PHONE No.	
REPORT COMPLETED BY			SIGNATURE	DATE	
TITLE			PHONE NUMBER		

Submit completed form to:

Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597

Email: claims@mem-ins.com

*Please complete
the diagram
on reverse side.*

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THIS REPORT TO BE COMPLETED BY INJURED EMPLOYEE.

NAME: _____

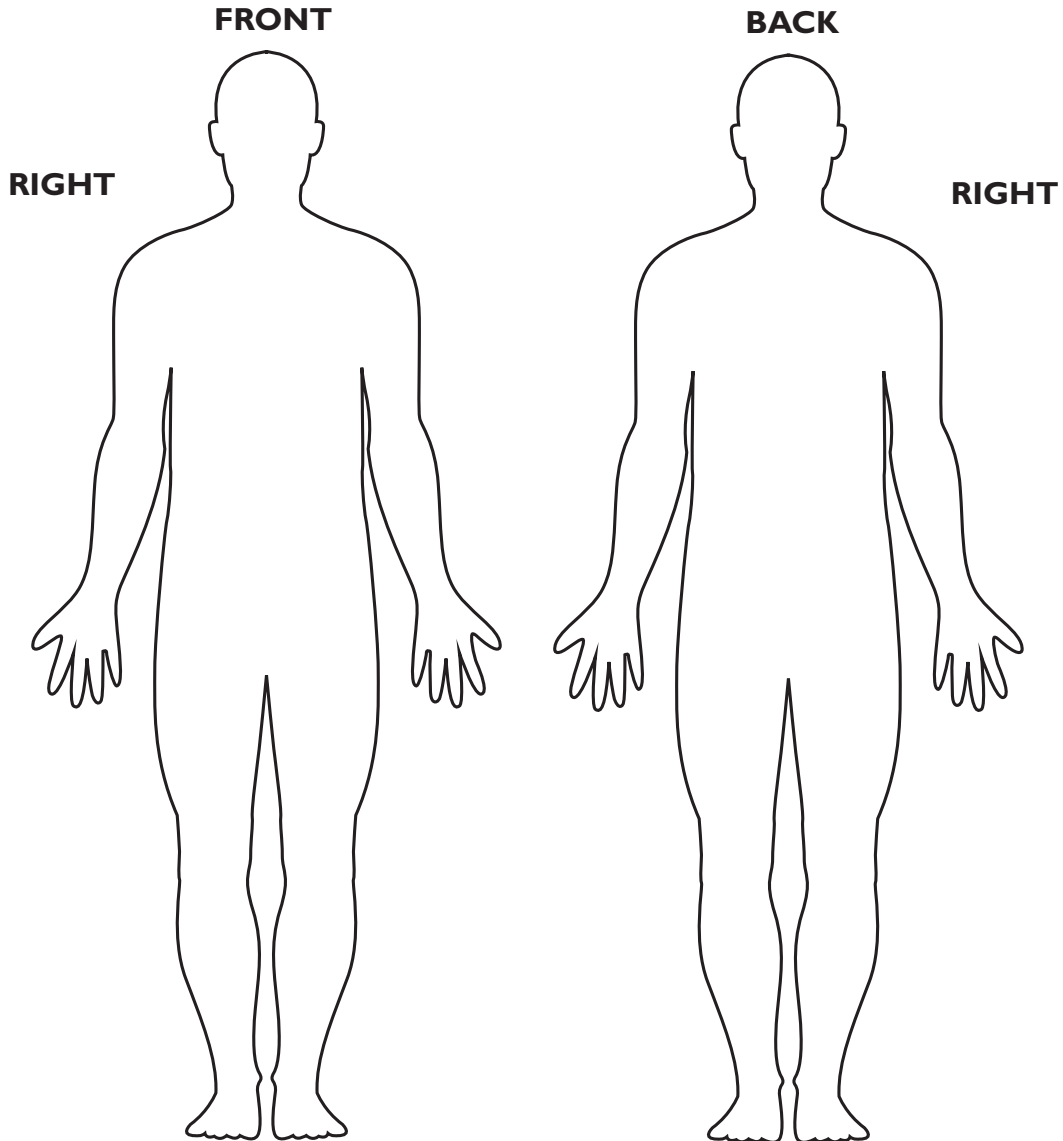
DATE: _____

DEPARTMENT: _____

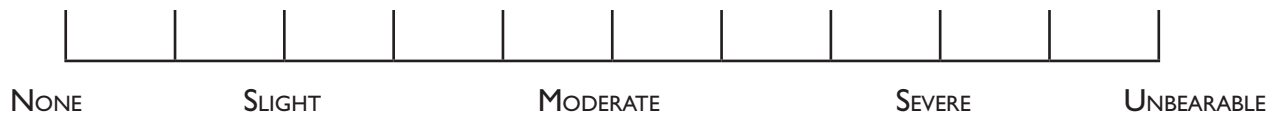
JOB: _____

MARK THE AREAS OF THE BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS WITH THE APPROPRIATE SYMBOLS FROM THE CHART BELOW.

NUMBNESS	+++++	SHARP	/////
BURNING	xxxxx	DULL & ACHING	*****
PINS & NEEDLES	00000	WEAKNESS	▽▽▽▽▽



Indicate Pain Level Below



SIGNATURE: _____ DATE: _____

WITNESS: _____ TITLE: _____ DATE: _____