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**WORKERS COMP MEDICAL ONLY REPORT FORM**

This form is to be used in reporting injuries involving outside medical costs and lost time injuries with less than seven days disability. Injuries of seven or more consecutive days of disability, not including date-of-injury, are to be reported on the Employer's Basic Report of Injury formerly Workers' Compensation Form 100.

Employer \_\_\_\_\_ Fed ID# \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_  
(Number & Street) (City & Zip)

Injured Employee \_\_\_\_\_ Phone# \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

Address \_\_\_\_\_ Zip \_\_\_\_\_  
(Number & Street) (City & Zip)

SSN \_\_\_\_\_ Marital Status \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_

Number of Dependents \_\_\_\_\_ Date of Hire \_\_\_\_\_ AWW (estimated) \$ \_\_\_\_\_

Occupation/Department of Injured Employee \_\_\_\_\_

Date of Injury \_\_\_\_\_ Time \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_ Date Employer Notified \_\_\_\_\_

Location Where Injury Occurred? City \_\_\_\_\_ State \_\_\_\_\_

Employment Status: Full-Time \_\_\_\_\_ Part-time \_\_\_\_\_ Other \_\_\_\_\_

Last Day Worked \_\_\_\_\_ Returned to Work \_\_\_\_\_

Nature of Injury  
Examples: Burn, Cut \_\_\_\_\_

Part of Body  
Examples: Eye, Arm \_\_\_\_\_

How Did the Alleged Injury Occur? (Describe fully the events which resulted in the injury or occupational disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use separate sheet of paper for additional space.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Names and Phone Numbers of Witnesses \_\_\_\_\_

Name and Address of Attending Physician \_\_\_\_\_

Name and Address of Hospital \_\_\_\_\_

Date of Report \_\_\_\_\_ By \_\_\_\_\_ (Phone( ) \_\_\_\_\_)

Mail to: **GALLAGHER BASSETT SERVICES, INC.**  
**PO BOX 1448**  
**EAST LANSING, MI 48826-1448**  
**Phone: (517) 351-3100**

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