

IS VALIDITY OF CLAIM DOUBTED? YES / NO

If Yes, please explain:

ON THE SCENE: TREATMENT INFORMATION

PRIMARY OUTCOME

IF TREATMENT REQUIRED, PLEASE CHECK ONE

INJURY

ILLNESS

DEATH

MEDICAL

FIRST AID

NONE

AT THE SCENE OF INJURY, DID ONE OF THE FOLLOWING OCCUR?

PATIENT TAKEN TO HOSPITAL

PATIENT FELL UNCONSCIOUS

FATAL INJURIES SUSTAINED

RESUSCITATION REQUIRED

AMBULANCE REQUIRED

IF FIRST AID GIVEN:

DATE OF FIRST AID

TIME OF FIRST AID GIVEN

EMPLOYEE NAME /PH#

NON EMPLOYEE NAME / PH#

AM / PM

WHERE WAS INJURY TREATED?

PHYSICIAN / HOSPITAL / FACILITY NAME

NAME OF FACILITY

PHYSICIAN NAME

ADDRESS

CITY, STATE, ZIP

PHONE NUMBER

WAS EMPLOYEE HOSPITALIZED OVERNIGHT? YES / NO

BILLING INFORMATION

PHYSICIAN'S INFORMATION

Arizona Department of Administration
Risk Management Division
Worker's Compensation Unit
100 N 15th Avenue, STE 301
Phoenix, AZ 85007
Phone (602) 542-5218
Fax (602) 542-1490
Web Site: www.azrisk.state.az.us

The **Worker's and Physician's Report of Injury** (Form 102) should be completed and signed at the health provider's office. If this form is not filled out, the Industrial Commission and insurance carrier will not be officially notified and claim activity can be delayed.

WITNESSES

1 WITNESS

CONTACT PHONE #

2 WITNESS

CONTACT PHONE #

NAME OF OTHERS INJURED IN THE SAME ACCIDENT:

IS PERSONAL PROTECTIVE EQUIPMENT REQUIRED?

YES / NO

WAS IT BEING WORN?

YES / NO

Supervisor's
Signature _____

Date _____

Time _____

Supervisor's Title _____

Phone # _____