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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS | | | | | | | | | | | | | | | | | | | | | | | |
| EMPLOYER (NAME AND ADDRESS INCL. ZIP)  **City of Gulfport** Post Office Box 1780Gulfport, MS 39502 | | | | | | | | CARRIER/ADMINISTRATOR CLAIM NUMBER | | | | | | | | | | | | | REPORT PURPOSE CODE | | |
|
| JURISDICTION | | | | | | | | JURISDICTION CLAIM NUMBER | | | | | | | |
| INSURED REPORT NUMBER | | | | | | | | | | | | | | | |
| EMPLOYER’S LOCATION ADDRESS (IF DIFFERENT) | | | | | | | | | | | | | LOCATION #: | | |
| SIC CODE | | EMPLOYER FEIN  **64-6000413** | | | | | | PHONE #228-868-5831 | | |
| **CARRIER/CLAIMS ADMINISTRATOR** | | | | | | | | | | | | | | | | | | | | | | | |
| CARRIER (NAME, ADDRESS & PHONE NO.) City of GulfportPost Office Box 1780Gulfport, MS 39502 **(228) 868-5811** | | | | | | | | POLICY PERIOD  TO | | | | | | | CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)  **Associated Adjusters, Inc.** Post Office Box 357 **Gulfport, MS 39502**  **(228) 865-9181** | | | | | | | | |
|
| CHECK IF APPROPRIATE   SELF INSURANCE | | | | | | |
| CARRIER FEIN  **64-6000413** | | POLICY/SELF INSURED NUMBER | | | | | | | | | | | | | | | | | | | ADMINISTRATOR FEIN  **64-0655545** | | |
| AGENT NAME AND CODE NUMBER  **Stewart, Sneed, & Hewes, Inc.** | | | | | | | | | | | | | | | | | | | | | | | |
| EMPLOYEE/WAGE | | | | | | | | | | | | | | | | | | | | | | | |
| NAME (LAST, FIRST, MIDDLE) | | | | | | DATE OF BIRTH | | | | | | SOCIAL SECURITY NUMBER | | | | | | | | DATE HIRED | | | STATE OF HIRE MS |
| ADDRESS (INCL. ZIP | | | | | | SEX  MALE  FEMALE  UNKNOWN | | | | | | MARITAL STATUS  UNMARRIED/SINGLE/DIVORCED  MARRIED  SEPARATED  UNKNOWN | | | | | | | | OCCUPATION/JOB TITLE | | | |
| EMPLOYMENT STATUS  FT | | | |
| PHONE | | | | | |  | | | | | | NCCI CLASS CODE | | | |
| RATE  **$** PER Hour | | | | | | | | | | | # DAYS WORKED/WEEK | | | | | FULL PAY FOR DAY OF INJURY? YES  NO  DID SALARY CONTINUE? YES  NO | | | | | | | |
| OCCURRENCE/TREATMENT | | | | | | | | | | | | | | | | | | | | | | | |
| TIME EMPLOYEE  BEGAN WORK | AM  PM | | DATE OF INJURY/ILLNESS | | | TIME OF OCCURRENCE  **AM**  **PM** | | | | | | | | LAST WORK DATE | | | DATE EMPLOYER NOTIFIE | | | | | DATE DISABILITY BEGAN  n/a | |
| CONTACT NAME/PHONE NUMBER  Catherine Williams / 228-868-5831 | | | | | | | | TYPE OF INJURY OR ILLNESS | | | | | | | | | | PART OF BODY AFFECTED | | | | | |
| DID INJURY/ILLNESS OCCUR ON EMPLOYER PREMISES?  YES  NO | | | | | | | | TYPE OF INJURY/ILLNESS CODE | | | | | | | | | | PART OF BODY AFFECTED CODE | | | | | |
| DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | | | | | | | | | | | | | ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED | | | | | | | | | | |
| SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | | | | | | | | | | | | | WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED | | | | | | | | | | |
| HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL. | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | CAUSE OF INJURY CODE | | | | |
| DATE RETURN(ED) TO WORK | | | | IF FATAL, GIVE DATE OF DEATH | | | | | | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?  YES  NO  WERE THEY USED?  YES  NO | | | | | | | | | | | | | |
| PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS) | | | | | | | | | HOSPITAL (NAME AND ADDRESS) | | | | | | | | | | INITIAL TREATMENT | | | | |
| NO MEDICAL TREATMENT | | | | |
| MINOR: BY EMPLOYER | | | | |
| MINOR CLINIC/HOSPITAL | | | | |
| EMERGENCY CARE | | | | |
| WITNESSES (NAME AND PHONE #) | | | | | | | | | | | | | | | | | | | HOSPITALIZED > 24 HOURS | | | | |
| FUTURE MAJOR MEDICAL \_ /LOST TIME ANTICIPATED | | | | |
| DATE ADMINISTRATOR NOTIFIED | | | | | DATE PREPARED | | PREPARER’S NAME & TITLE | | | | | | | | | | | | PHONE NUMBER | | | | |
|  | | | | |  | |  | | | | | | | | | | | | **228.868.5831** | | | | |

CITY OF GULFPORT – EMPLOYEE ACCIDENT OR INJURY REPORT

Employee Information: Please Print Clearly

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employee Name: |  | Date of Birth: | | Employee ID # | | | | Employee ID # |  |
| SSN# | Home Phone # | | Work Phone # | | |
| Address: |  | | | | Marital Status: | |  | | | |

OCCURRENCE/TREATMENT INFORMATION:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Accident: | |  | | | | | | | | | Time of Accident: | | | | |  | | | |
| Time You Began Work on Date of Accident: | | | | | | | | |  | | | | | | | | | | |
| Where did accident occur? | | | | | |  | | | | | | | | | | | | | |
| Date Employer Notified: | | |  | | | | | | | | Who was notified? | | | | |  | | | |
| Were you injured in the accident? ❑YES ❑NO | | | | | | | | | | | | Type of Injury: | | | |  | | | |
|  | | | | | | |  | | | | | | | | | | | | |
| Specific Body Part(s) Injured: | | | | | | |  | | | | | | | | | | | | |
| Specific activity involved in at time of injury/illness: | | | | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |  | |
| Describe in detail how the accident occurred and how you were injured or fell ill: | | | | | | | | | | | | | | | | | |  | |
|  | | | | | | | |  | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | |
| Who witnessed this accident? | | | | | | | |  | | | | | | | | | | | |
| Were you using any equipment, materials or chemicals at the time of the Accident? | | | | | | | | | | | | | | | | | | | ❑ YES ❑ NO |
| If yes, what equipment, materials or chemicals were you using? | | | | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| What safety equipment was provided, if any? | | | | | | | | | |  | | | | | | | | | |
| If any, were you using it? | | | | |  | | | | | | | | | | | | | | |
| Did you seek medical treatment? ❑YES ❑NO | | | | | | | | | | | If yes, who did you see and who referred you to | | | | | | | | |
| that medical provider? | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  | | | | |
| Did the medical provider return you to work? ❑YES ❑NO | | | | | | | | | | | | | |  | | | | |
| If yes, did you have any work restrictions? ❑YES ❑NO | | | | | | | | | | | | | |  | | | | |
| If yes, please describe: | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  | | | | |
| Employee’s Signature: | | | |  | | | | | | | | | | Date: | | |  | | |

**NOTE: PLEASE FORWARD WITHIN 24 HOURS OF ACCIDENT TO HUMAN RESOURCES**

**Notice**

**To**

**Mississippi Workers’ Compensation Commission**

**Physician of Choice**

Claimant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Injury Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that under the Mississippi Workers’ Compensation law I have the right to choose one physician to render treatment to me. I can either accept the physician to whom I am sent by my employer or choose someone else on my own.

I also understand that any referral to any other doctor **must** be made by my one chosen physician.

I also understand that my employer (or workers’ compensation carrier/administrator) must approve any physician change, and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

I accept as my choice of physician my employer’s tender of treatment by:

**Medical Analysis, 3310 17th Street, Gulfport, MS 39501~ 228-863-6760**

I elect to choose my own physician to render treatment, and that choice is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s Signature Date