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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 STATUSFT |
| 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 BEGANn/a |
| CONTACT NAME/PHONE NUMBERCatherine 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 [ ]  NOWERE THEY USED? [ ]  YES [ ]  NO |
| PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS) | HOSPITAL (NAME AND ADDRESS) | INITIAL TREATMENT |
| [ ]  NO MEDICAL TREATMENT |
| [ ]  MINOR: BY EMPLOYER |
| [x]  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:

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

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Employee’s Signature Date