Constitution State Services

Workers Compensation Claim Reporting Worksheet and Guide

We will produce and submit the necessary state forms and filings.
DO NOT DELAY IN REPORTING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.
PLEASE EMAIL YOUR COMPLETED FORM TO LossRptCSS@constitutionstateservices.com OR CALL 800.243.2490.

ACCOUNT INFORMATION

PREPARER'S PHONE NUMBER AND EMAIL ADDRESS	PREPARER'S TITLE AND NAME	IN WHICH STATE DOES THE INJURED EMPLOYEE PRIMARILY WORK
SUBSIDIARY (COMPANY) NAME	SUBSIDIARY (COMPANY) ADDRESS (STREET, CITY, STATE & ZIP)	SUBSIDIARY (COMPANY) MAILING ADDRESS (STREET, CITY, STATE & ZIP) ☐ SAME
DID THE LOSS OCCUR AT THE LOCATION ADDRESS? (IF "NO", ADDRESS WHERE LOSS OCCURRED) ☐ YES ☐ NO		
PARENT COMPANY/INSURED'S NAME		
LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS
DATE OF INJURY	TIME OF INJURY	
ACCIDENT DESCRIPTION		

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER ☐ MALE ☐ FEMALE	PRIMARY LANGUAGE
DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS		
EMPLOYEE'S PHONE NUMBER	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)	EMPLOYEE'S EMAIL ADDRESS	

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE ☐ FULL-TIME ☐ PART-TIME ☐ OTHER	REGULAR ASSIGNED DEPARTMENT	REGULAR OCCUPATION
OCCUPATION WHEN INJURED		

EMPLOYEE'S WORK SCHEDULE

REGULAR WORK HOURS	HOURS/DAY	DAYS/WEEK

EMPLOYEE'S WAGE INFORMATION

HOUR	OR ANNUAL	OR WEEKLY	OVERTIME	ADD'L BENEFITS

DATE OF HIRE OR LENGTH OF EMPLOYMENT			
SUPERVISOR'S NAME	SUPERVISOR'S PHONE NUMBER	SUPERVISOR'S EMAIL ADDRESS	BEST HOURS TO CONTACT

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK OR ARE THEY WORKING MODIFIED DUTY BEYOND THE DATE OF THE INJURY? ☐ YES ☐ NO	IS THE EMPLOYEE BACK AT WORK? ☐ YES ☐ NO IF YES, DATE RETURNED TO WORK IS THERE AN ANTICIPATED RETURN TO WORK DATE? ☐ YES ☐ NO IF YES, ANTICIPATED RETURN DATE
RETURN TO WORK STATUS ☐ LIGHT ☐ MODIFIED ☐ REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH ☐ YES ☐ NO
DO YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE INJURY? ☐ YES ☐ NO	IF YES, WHAT ARE YOU QUESTIONING? ☐ WORK-RELATED INJURY ☐ EXTENT OF INJURY ☐ OTHER	

WITNESS INFORMATION

NAME (FIRST, MI, LAST)	PHONE NUMBER
ADDRESS	
NAME (FIRST, MI, LAST)	PHONE NUMBER
ADDRESS	
NAME (FIRST, MI, LAST)	PHONE NUMBER
ADDRESS	

INJURY INFORMATION

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

PRIOR INJURY OR PREEXISTING CONDITION(S) (IF YES, PLEASE DESCRIBE)

- ☐ YES
- ☐ NO

TREATMENT ("X" BY ALL THAT APPLY)

- ☐ UNKNOWN
- ☐ NO MEDICAL TREATMENT
- ☐ FIRST AID/MINOR ON-SITE TREATMENT
- ☐ DOCTOR'S OFFICE/WALK-IN CLINIC
- ☐ EMERGENCY ROOM
- ☐ HOSPITAL/CLINIC – ADMITTED >24 HOURS

DESCRIPTION OF TREATMENT AND DATE OF FIRST TREATMENT

NAME, ADDRESS, PHONE NUMBER OF TREATING FACILITY

PHYSICIAN'S NAME

INSURED CONTACT INFORMATION

CONTACT NAME, PHONE NUMBER, EMAIL ADDRESS, AND BEST TIME TO CONTACT AND WHERE TO CONTACT

ADDITIONAL NOTES/COMMENTS OR CUSTOMER-SPECIFIC INFORMATION