



## City of Englewood Employee Accident Form

EMPLOYEE NAME	I.D.	TIME OF INJURY	DATE OF INJURY	FILE NUMBER
PLEASE LIST YOUR PRIMARY CARE PHYSICIAN(S) AND HIS/HER/THEIR ADDRESS FOR THE PAST TEN YEARS				
BRIEFLY DESCRIBE HOW YOU GOT HURT AND WHEN THE INJURY OR ILLNESS OCCURRED.				
WHAT PART(S) OF THE BODY WERE HURT; AND IN WHAT PART(S) OF THE BODY DO YOU CURRENTLY FEEL PAIN?				
HAVE YOU HAD TREATMENT IN THE PAST FOR THE SAME OR SIMILAR MEDICAL CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE THE NAME AND ADDRESS OF THE TREATING PHYSICIAN(S) FOR THIS CONDITION. LIST ANY MEDICATIONS YOU ARE OR WERE TAKING FOR THIS CONDITION/INJURY?				
HAVE YOU BEEN TREATED IN THE PAST BY A CHIROPRACTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE THE NAME AND ADDRESS OF THE CHIROPRACTOR(S).				
HAVE YOU FILED ANY WORKERS' COMPENSATION CLAIM(S) IN THE PAST FOR THIS MEDICAL CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE THE DETAILS OF THE PREVIOUS CLAIM(S).				
HAVE YOU EVER BEEN INVOLVED IN ANY MOTOR VEHICLE COLLISIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE THE DETAILS OF THE CRASH, DATE, AND THE NATURE OF THE INJURY AND TREATMENT.				
ARE YOU CURRENTLY ENGAGED IN ANY OTHER EMPLOYMENT OR HAVE YOU EVER BEEN ENGAGED IN ANY OTHER EMPLOYMENT WHILE YOU WERE EMPLOYED BY US? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST THE NAMES AND ADDRESSES OF THESE EMPLOYERS.				
DO YOU CURRENTLY (IN THE PAST 12 MONTHS) PARTICIPATE IN ANY ATHLETIC, RECREATIONAL OR SPORTING ACTIVITIES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST THE ACTIVITIES YOU PARTICIPATE IN.				
TO WHOM DID YOU FIRST REPORT THE INJURY TO AND WHEN?				
WERE THERE ANY WITNESSES TO YOUR INJURY? IF SO, WHO?				
HAVE YOU EVER RECEIVED PAIN MANAGEMENT TREATMENT? IF SO, BY WHOM?				

**I CERTIFY THAT THE ABOVE STATEMENTS MADE BY ME ARE TRUE AND CORRECT. I AM AWARE THAT IF ANY OF THE STATEMENTS ARE WILLFULLY FALSE, I MAY BE SUBJECT TO DISCIPLINARY ACTION BY MY EMPLOYER.**

EMPLOYEE SIGNATURE & DATE
SUPERVISOR'S SIGNATURE & SUPERVISOR'S NAME PRINTED