Employee Notice of Injury

7102 North Sam Houston Parkway West, Suite
200 Houston, Texas 77064

Phone: 888.983.5881
Fax: 281.377.7029

Employee Name (last, first, middle)	Social Security #:	Phone:	
Street Address	City	State	Zip Code

Occupation:	State where employment agreement was made:	Average weekly wage:	Length of employment: Months _____ Years _____

Date of Accident of Last Exposure:	Time: _____ AM _____ PM	Place of Injury: City/County/State
Body Parts Injured:	Describe in detail how the injury occurred.	

Treating Physician (full name):	Address:	City:	State:	Zip:

Name of Co -employer		Job site location:

Are you a previously impaired person due to prior workers' compensation injury or obvious pre-existing disability caused by accident, disease, birth defect or military injury that may impact the treatment of this injury?_____ If "Yes", please describe:

Date:	Description:	Physician:

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier and change in material fact, or the amount of income he/she is receiving, or any change in his/her employment status, occurring during the period of receipt of such benefits.

I declare under penalty of perjury that I have examined this notice and claim, and all statement contained herein, and the best of my knowledge and belief, they are true, correct and complete.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Upon Filing this Notice of Accidental Injury and Claim for Compensation permission is given to the Administrator of the Workers' Compensation Court, the Insurance Commissioner, the Attorney General, a District Attorney, the Insurance adjuster or their designees authorizes them access to medical records, including waiver of any privilege granted by law concerning communications made to a physician or health care provider or knowledge obtained by such physician or health care provider by personal examination.

The information authorization for release may include information, which may be considered, a communicable, or venereal disease which may include but not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired deficiency syndrome.

Signed this _____ day of _____ , _____

_____ _____

Employee Signature **Printed Employee Name**

This form constitutes a medical authorization for release of medical records. Nothing shall be constructed to waive, limit or impair any evidentiary privilege by law.

Employer Flexible™
Impact what matters™