

EMPLOYEE'S REPORT OF ACCIDENT

Name _____ Address _____

Tel. # _____ Social Security # _____ D. O. B. _____

Employer's Name & Address _____

_____ Employer's Telephone # _____

Occupation _____ How Long Employed _____

Wages _____ Date & Time of Accident _____

Where & How Accident Happened (address) _____

Name of Witness (if any) _____

Was the accident caused by someone other than co-worker? _____

If yes, Name & Address _____

What part of the body did you injure? _____

Length of scar, number of stitches, color and description _____

Name of hospital you went to _____

Name & Address of Doctor(s) who treated you _____

Are you still under treatment? _____ Date last treated _____

Did you lose wages due to accident? _____ Date last paid _____

Date you stopped working _____ Date returned to work _____

Who did you return to work for? _____

List prior accidents (with dates) _____

List prior Doctors _____

Date _____ Signed _____

NH 03 5/12

**HOSPITAL) PERMISSION SLIP
DOCTOR)**

To:

Claimant :
Insured :
Date of Acc. :
Claim No. :

Permission is granted to furnish A.I.M. Mutual Insurance Cos. and their authorized agents or representatives, as well as the above named insured/employer, with a copy of my record of treatment for the above date of accident.

Lab Rule 503.01(b): This request is strictly limited to medical information relevant to the occupational injury or illness that underlies the patient's workers compensation claim, including any past history of complaints of, or treatment of, a condition similar to that claim.

A.I.M. Mutual Insurance Cos. will be responsible for payment of your usual charge for such a copy.

You are authorized to permit the examining physician for A.I.M. Mutual Insurance Cos. to examine any x-ray or films you may have concerning my condition.

My permission is also given for you to accept a photocopy of this authorization.

(Signature)

(Date of Birth)

(Date)

Send Record to:

**A.I.M. Mutual Insurance Cos.
P.O. Box 4070
Burlington, MA 01803-0970**

NH 01 7/16