ATHLETICO
PHYSICAL THERAPY

Injured Worker (Employee) Incident Form

When completed, please submit to Compliance@athletico.com.

Last Name **First Name** **Initial**

Home Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Cell/Home Phone: _____ Gender: _____

DOB: _____ Personal E-Mail Address: _____ Hire Date: _____

Marital Status: _____ Number of Dependents: _____

Position: _____ Facility: _____ Supervisor: _____

Days Per Week: _____ Hours Per Day: _____ Rate of Pay: _____

INCIDENT DETAILS

Date of Incident: _____ Date of Supervisor Notification: _____

Did Incident Occur on Employer Premises? _____ Clinic Name/Facility Code: _____

Incident Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

Description of Incident – Including Body Part Injured: _____

_____

_____

_____

Witnesses to Incident: Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

MEDICAL ATTENTION

Was Medical Attention Sought? _____ If Applicable, Name of Provider: _____

If Applicable, Address of Provider: _____

If Applicable, City of Provider: _____

If Applicable, State of Provider: _____ If Applicable, Zip of Provider: _____

If Applicable, Phone Number of Provider: _____

Name of Preparer: _____ Signature of Preparer: _____ Date Prepared: _____