REPORT OF INJURY

WORKERS' COMPENSATION PROGRAM
THE NAVAJO NATION - P.O. BOX 2489
WINDOW ROCK, AZ 86515-2489
PHONE: 928-871-6389
FAX: 928-871-6083

Workers' Comp Use Only	
Claim #	
Date Received	

Employer

1. Name of Company/Department/Program/Chapter/Enterprise		2. If PEP; Project Number	
3. Address	4. City or Town	5. State	6. Zip Code
7. Mailing Address – if different from above		8. Phone Number	9. Fax Number

Accident

10. Location Where Accident Occurred			11. Employers Premises Yes ☐ No ☐
12. Date of Injury	13. Time of Injury	14. Time work day begins	15. Date Disability Began
16. Was Injured Paid in Full for this Day Yes ☐ No ☐		17. Date supervisor was notified of injury	
18. Immediate Supervisors name		19. Supervisor's Phone Number	
20. Name, address and phone number of witness:		21. Name, address and phone number of witness:	

Injured Employee

22. Employee's Name (First, Middle, Last)	23. Gender	24. Social Security Number	25. Date of Birth
26. Mailing Address	27. City	28. State	29. Zip Code
30. Physical Address	31. Phone Number	32. Email Address	
33. Marital Status Married ☐ Single ☐ Divorced ☐ Widowed ☐		34. Date Hired	
35. Occupation when injured	36. How long at present occupation when injured	37. Employment Status Regular ☐ Temp ☐ Elected Official ☐ Volunteer ☐	
38. Number of hours worked per day:	39. Number of days worked per week:	40. Hourly wage at the time of injury:	
41. Other wages earned such as tips, stipends or other income is furnished in addition to regular wages, give amount: $ Per			
42. Date employee returned to work	43. Estimate length of disability Fr: To:	44. Type of leave taken Annual ☐ Sick ☐ Comp ☐ LWOP ☐ PTO ☐	

Cause of Injury

45. Describe in detail how accident happened and what employee was doing when injured. (Do not state "See Attached")

Nature of Injury

46. Describe the nature of the injury of diseases in detail and indicate the part of the body effected (e.g., Right? Left? Both) (Do not state "See Attached")		
47. Is the employee likely to lose more than seven (7) days due to injury/disease	48. Name of Physician and address	
49. Address of hospital		50. Date of first examination
51. If no treatment, does employee plan to seek medical treatment	52. FATAL CASE ONLY. Has injured died?	53. Date of Death if Applicable

Report Completed By		*NNWCP Date Stamp Here:*
Signed By		
Title	Date	

ARE ALL ITEMS COMPLETED? SIGN AND MAIL IMMEDIATELY TO THE ABOVE ADDRESS.