USE THIS FORM OR THE FORM DEVELOPED BY YOUR AGENCY

STATE OF ARIZONA	Supervisor's Report of Injury / Illness (SRI)	WORKERS' COMPENSATION

***Have Employee call the *Employee Injury Call Center* at 1-800-685-2877 fk]h\ ]b`&( `\ ci fgŁ

In addition to calling the 800#, this form must be completed by the Supervisor (immediately)

WORKER'S INFORMATION

LAST NAME, FIRST NAME, MI	SOCIAL SECURITY #	EIN #	DATE OF BIRTH (Day, Month, Year)

HOME ADDRESS, CITY, ZIP CODE	HOME PHONE	# OF DEPENDENTS	MARITAL STATUS	GENDER
			S M D W	``AUY : Ya UY

EAD@CMD9 9fG`K CF? `G7 <98I @9 Gi b```Acb```Hi Y``K YX```H\ i ````: f]````GUh `K CF? `<CI FG	EMPLOYEE'S AGENCY/DIVISION/SECTION

EMPLOYEE SUPERVISOR'S LAST NAME, FIRST NAME, MI	SUPERVISOR'S PHONE #	SPVSRfG G97 H=CB	EMPLOYEE'S JOB TITLE

WAS WORKER IN YOUR EMPLOY WHEN INJURED?	WAS WORKER ON OVERTIME WHEN INJURED?	WAS WORKER PAID FOR DAY OF INJURY?	IS WORKER A STATE OF ARIZONA EMPLOYEE?
Yes No	Yes No	Yes No	Yes No
DATE OF LAST HIRE:			

INJURY / ILLNESS DETAILS

DATE OF INJURY	TIME OF INJURY	DATE AND TIME INJURY REPORTED
		enter as m/d/yy h:mm tt

LAST DATE WORKED	DID INJURY OCCUR ON EMPLOYER PREMISES3	ADDRESS OR LOCATION OF INCIDENT	PART(S) OF BODY INJURED
DATE EMPLOYEE RETURNED TO WORK (IF APPLICABLE)	Yes No		@Yzh`` `F][\ h 6 ch\

NATURE OF INJURY (IE, STRAIN, BRUISE, CUT)	`EVENT TYPE (IE, @=Hž ``SLIP, TRIPž: 5 @@	DID INCIDENT RESULT IN ILLNESS? WHAT SYMPTOMS WERE EXPERIENCED?

SOURCE OF INJURY (IE, AUTOMOBILE, COMPUTER)	MACHINE, TOOL OR OBJECT MOST CLOSELY CONNECTED WITH INCIDENT	WHEN DID ONSET OF SYMPTOMS OCCUR?

INJURY / ILLNESS DETAILS: WHAT HAPPENED?

K 5 G`H<9 F9 `5 `H<=F8 `D5 FHM F9 GDCB=6 @9 `: CF `H<9 `B>I FM? Yes No

=ZMYgžd`YUgY`dfcj]XY`h\ Y`Zc``ck]b[.

B5 A9 `C: `F9 GDCBG=6 @9 `D5 FHM D<CB9 `BI A6 9F.

5 8 8 F9 GG. 7 =HMž GH5 H9 žN=D.`

=BGI F5 B7 9 `7 5 FF=9 F.`

Note: Form functionality may vary if using a program other than Acrobat or Adobe Reader 7.0.5 or later.

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IS VALIDITY OF CLAIM DOUBTED? Yes No
If Yes, please explain:

ON THE SCENE: TREATMENT INFORMATION

PRIMARY OUTCOME

INJURY ILLNESS DEATH

IF TREATMENT REQUIRED, PLEASE CHECK ONE

##############MEMEDICAL FIRST AID NONE

AT THE SCENE OF INJURY, DID ONE OF THE FOLLOWING OCCUR?

PATIENT TAKEN TO HOSPITAL PATIENT FELL UNCONSCIOUS FATAL INJURIES SUSTAINED

RESUSCITATION REQUIRED AMBULANCE REQUIRED

IF FIRST AID GIVEN:

EMPLOYEE NAME NON EMPLOYEE NAME

DATE OF FIRST AID

TIME FIRST AID GIVEN PHONE NUMBER PHONE NUMBER

WHERE WAS INJURY TREATED?

PHYSICIAN / HOSPITAL / FACILITY NAME	
NAME OF FACILITY	
PHYSICIAN NAME	
ADDRESS	
CITY, STATE, ZIP	
PHONE NUMBER	

WAS EMPLOYEE HOSPITALIZED OVERNIGHT? Yes No

WITNESSES

# 1 WITNESS	CONTACT PHONE #
# 2 WITNESS	CONTACT PHONE #

NAME OF OTHERS INJURED IN THE SAME ACCIDENT:

IS PERSONAL PROTECTIVE EQUIPMENT REQUIRED? Yes No

WAS IT BEING WORN? Yes No

***Have Employee call the *Early Reporting Claims Service* at 1-800-685-2877 within 24 Hours**

FAX COMPLETED FORM TO 602-382-2380, OR EMAIL WORKERS.COMP@AZDOA.GOV

Supervisor's Signature Date Time

Supervisor's Title Phone #

Arizona Department of Administration
Risk Management Division, Workers' Compensation
100 Ncfh\ 15th Avenue, Si]hY˙301
Phoenix, AZ 85007
Phone (602) 542-2182 | Fax (602) 382-2380
Web Site: www.staterisk.az.gov

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