



REPORT OF INJURY

WORKERS' COMPENSATION PROGRAM

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THE NAVAJO NATION - P.O. BOX 2489

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WINDOW ROCK, AZ 86515-2489

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 <input type="checkbox"/> No <input type="checkbox"/>	
	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 <input type="checkbox"/> No <input type="checkbox"/>				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 <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>						34. Date Hired		
	35. Occupation when injured		36. How long at present occupation when injured		37. Employment Status Regular <input type="checkbox"/> Temp <input type="checkbox"/> Elected Official <input type="checkbox"/> Volunteer <input type="checkbox"/>				
	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 <input type="checkbox"/> Sick <input type="checkbox"/> Comp <input type="checkbox"/> LWOP <input type="checkbox"/> PTO <input type="checkbox"/>			
Cause of Injury	45. Describe in detail how accident happened and what employee was doing when injured. (Do not state "See Attached")								
	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")								
Nature of injury	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 _____								
Signed By _____									
Title _____				Date _____		NNWCP Date Stamp Here:			
ARE ALL ITEMS COMPLETED? SIGN AND MAIL IMMEDIATELY TO THE ABOVE ADDRESS.									