CIRMAcare

Print Form

CIRMA Injury Reporting Information

Report Claims at NetClaim.net or 1-800-OK-CIRMA

Keep this Form for your own Records—Do Not Submit to CIRMA

Event Date/Time

Incident Date and Time: _____ Employer Notified: _____

Reporter & Location Information

Reported by: _____ Title: _____ Phone Number: _____

Location Code: _____ Location Name: _____ Address: _____

Claimant Information

Social Security Number of Claimant: _____

Claimant Name: _____

Home Phone: _____ Work Phone: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Marital Status: _____ Gender: ☐ Male ☐ Female

Employment

Job Title: _____ Status: _____

Claimant's Supervisor: _____ Title: _____ Phone: _____

Incident

Description of the Injury: _____

_____

Cause: _____ Body Part: _____

Nature Code: _____

Medical Provider (if known): _____ Address of Medical Provider: _____

Name of Doctor (if known): _____

Witness Name (if any): _____

Lost time from work (if known): _____ Return to work date: _____

Loss Location Entity: _____

Address: _____

Contact Person: _____

Additional Information

Job Classification code: _____

Time the employee began work on the day of injury: _____

Supervisor Notice Date: _____ Claim Incident Number: _____

This is assigned by NetClaim.net (at the FINISH tab) or by the Hotline operator.

Rev. 021014