



Name
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If you need additional space, use the other side or additional sheets.

**Injury/accident information**

Event	Details/comments
When and where did the injury occur?	
How did it happen?	
What is the nature of your injury?	
Who did you notify and when?	
Who was there to help you?	
How do you prevent another injury?	

**Workers' compensation claim information**

Event	Date/time	Details/comments
Claim form completed and who completed it		
Received letter from BWC acknowledging claim receipt and it included your card		Claim number
		Claims service specialist's (CSS's) name:
		CSS's phone number
Received claim decision (allow or disallow) from BWC		
Received letter from managed care organization (MCO)		MCO's name
		Case manager's name
		Case manger's phone number

**Medical care information**

Event	Date/time	Details/comments
Initial visit – Name of doctor, facility, diagnosis and treatment		
First follow-up visit – Name of doctor, facility, diagnosis and treatment		

**Return to work**

Event	Date/time	Details/comments
Returned to suitable tasks with limitations (light duty)		
Returned to work full duty		





