



**INDUSTRIAL COMMISSION OF ARIZONA**  
800 W WASHINGTON STREET  
PHOENIX, ARIZONA 85007  
(602) 542-4661  
**WORKER'S & PHYSICIAN'S REPORT OF INJURY**

IMMEDIATELY UPON COMPLETION PLEASE  
MAIL COPIES AS SHOWN BELOW

**INJURED WORKER'S RIGHT TO CHOOSE DOCTOR**

An employer who is not self-insured can direct you to a doctor of their choice for ONE visit. After the **ONE** visit, you may report to a doctor of your choice. **REMEMBER:** If you make a **SECOND** visit to the employer's doctor, you have established that doctor as your treating doctor. If your employer is self-insured, you may not be allowed to change doctors. **SEE INFORMATION SHEET ATTACHED TO THIS FORM FOR FURTHER INSTRUCTIONS.**

**WORKER'S REPORT**

NAME OF INJURED WORKER LAST NAME			FIRST	M.I.	SOCIAL SECURITY NO.		ICA USE ONLY INJURY CODE: _____	
					PHONE NO.			
1. ADDRESS			CITY		STATE		ZIP	
3. DATE OF BIRTH			4. SEX: MALE FEMALE					
5. SINGLE WIDOWED DIVORCED			MARRIED		IF SO, IS SPOUSE EMPLOYED YES NO			
6. OCCUPATION WHEN INJURED					DATE OF INJURY		TIME OF INJURY	
7. OT ÚŠJYÖÜ			SUPERVISOR				PHONE NO.	
8. OFFICE ADDRESS					CITY		STATE ZIP	
9. EMPLOYER'S INSURANCE CARRIER							POLICY NO.	
10. MAILING ADDRESS								
11. DESCRIBE WHERE AND HOW ACCIDENT OR CAUSE OF DISABILITY OCCURRED (INCLUDING LOCATION AND/OR DEPARTMENT)								
BY THIS INSTRUMENT I MAKE APPLICATION FOR ALL BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE LAW AND I DO HEREBY CERTIFY, WITH FULL KNOWLEDGE THAT IT IS A CRIME TO MAKE WILLFUL, FALSE STATEMENTS TO OBTAIN COMPENSATION, THAT ALL OF MY STATEMENTS ON THIS FORM ARE TRUE, ACCURATE AND COMPLETE. I UNDERSTAND I MUST FOLLOW THE INSTRUCTIONS OF MY DOCTOR AND MUST HAVE WRITTEN APPROVAL FROM THE INDUSTRIAL COMMISSION TO LEAVE THE STATE OF ARIZONA OR MY LOCALITY FOR MORE THAN 14 DAYS. FAILURE TO DO SO MAY CAUSE FORFEITURE OF COMPENSATION BENEFITS.								
WORKER EMAIL ADDRESS			DATE OF SIGNING		AT		CITY STATE	
EMPLOYER EMAIL ADDRESS								
<b>IMPORTANT:</b>			INJURED WORKER'S SIGNATURE REQUIRED HERE		<b>X</b>			

**PHYSICIAN'S INITIAL REPORT**

12. DATE FIRST TREATMENT			HOUR		13. LOCATION: HOSPITAL OFFICE OTHER		
14. DATE WORKING DISABILITY BEGAN			15. WHO ENGAGED YOUR SERVICES? PATIENT EMPLOYER OTHER				
16. WAS PATIENT TREATED BY ANYONE ELSE? YES NO			IF YES, BY WHOM?				
17. COMPLAINTS AND PHYSICAL FINDINGS IN DETAIL:							
18. ICD- CODE			DIAGNOSIS:				
19. DESCRIBE ANY PRE-EXISTING IMPAIRMENT OR DISEASE AFFECTING PRESENT CONDITION					20. PATIENT IS RIGHT LEFT HANDED		
21. DESCRIBE TREATMENT GIVEN BY YOU:							
22. WERE X-RAYS TAKEN? YES NO IF YES, BY WHOM?					WHEN		
23. WAS LABORATORY WORK DONE? YES NO IF YES, BY WHOM?					WHEN		
24. X-RAY DIAGNOSIS (ATTACH ROENTGENOLOGICAL REPORT FORM)							
25. WAS PATIENT HOSPITALIZED? YES NO IF YES, WHERE							
26. DATE OF ADMISSION TO HOSPITAL			27. DATE OF DISCHARGE				
28. IS FURTHER TREATMENT NEEDED? YES NO IF YES, FOR HOW LONG							
29. IS PATIENT, AS A RESULT OF CONDITIONS DUE TO THIS ACCIDENT: (A) SUBJECT TO SUSTAIN A PERMANENT DEFECT OF IMPAIRMENT? YES NO							
(B) ABLE TO DO THE SAME TYPE OF WORK HE PERFORMED AT TIME OF INJURY? YES NO IF YES, DATE ABLE					IF NOT, ANTICIPATED DATE		
(C) ABLE TO DO A LIGHTER OR DIFFERENT TYPE OF WORK THAN PERFORMED AT TIME OF INJURY? YES NO					IF YES, DATE ABLE		
IF NOT, ANTICIPATED DATE ABLE							
30. REMARKS:							
NAME OF PHYSICIAN					BILLING CODE NO.		
ADDRESS					ZIP PHONE		
IRS. NO.			PROFESSIONAL CORP? YES NO				
DATE OF THIS REPORT			PHYSICIAN'S SIGNATURE REQUIRED HERE		<b>X</b>		

## Information for Completing Worker's and Physician's Report of Injury

### Detach this Sheet and Give to Patient

Answer all questions in full. Use ball point pen or typewriter.

#### **Injured worker:**

This is the claim that will be used to notify the Industrial Commission, your employer and your employer's insurance carrier of your claim for workers' compensation benefits.

**This form must be completed in full and all questions answered.  
Your claim for benefits cannot be promptly processed without  
the following:**

Full Name of Your Employer  
Employer's Complete Address  
Employer's Phone Number  
Your Exact Date of Injury (Month-Day-Year)  
Your Signature  
Social Security Number \*

#### **Right to choose physician:**

When an injury occurs an employer has the right to have an injured worker seen by a doctor of the employer's choice one time. **(If you return to that physician a second time, that physician would become your attending physician).** After the one visit to the employer's designated physician you may report to a physician of your choice. **Exception:** if your employer is self-insured you must follow the self-insured employer's directed care program. To determine if your employer is self-insured, you may contact the Industrial Commission of Arizona Claims Division at (602) 542-4661.

**If you wish to change physicians after your initial selection, please contact the Industrial Commission of Arizona at (602) 542-4661**

#### **Medical provider:**

The worker's and physician's report of injury must be filed within eight (8) days after first rendering treatment. Mail the original to the Industrial Commission of Arizona at P.O. Box 19070, Phoenix, AZ 85005 and one (1) copy to the employer and one (1) copy to the employer's insurance carrier.

#### **Form available in alternative format:**

The Industrial Commission complies with the Americans with Disabilities Act of 1990. If you need this document in alternative format, contact Claims at (602) 542-4661.

\* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7 (a)(2)(b) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.