MCD ACCIDENT REPORT
TO BE USED WHEN SUBMITTING A CLAIM FOR REIMBURSEMENT

OWNER NAME _____ OWNER TELEPHONE (_____) _____-_____

OWNER ADDRESS _____

STORE # _____ STORE CITY _____ STORE PHONE (_____) _____-_____

STORE MANAGER NAME _____

INCIDENT DATE _____/____/____ TIME _____ am/pm EMPLOYEE APPLICATION DATE ____/____/____

EMPLOYEE ACTIVITY AT TIME OF ACCIDENT _____

EXACT INCIDENT LOCATION _____ OBJECT/THING CAUSING INJURY _____

DESCRIPTION OF INCIDENT _____

EMPLOYEE NAME _____ S.S. # _____-_____-_____

EMPLOYEE ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH: _____/_____/_____ HOME PHONE # (_____) _____-_____

JOB TITLE: _____ DUTIES: _____

HIRE DATE: _____/_____/_____ WAGE: $_____/HOUR HOURS PER WEEK _____

LIGHT/MODIFIED DUTY AVAILABLE _____ RETURN TO WORK DATE _____/_____/_____

RESTRICTIONS _____ LENGTH OF LIGHT DUTY _____

LENGTH OF DISABILITY _____ NATURE OF INJURY _____

MEDICAL PROVIDER(S)

(1) _____ (____) ____-_____
NAME ADDRESS PHONE

(2) _____ (____) ____-_____
NAME ADDRESS PHONE

TREATMENT RENDERED _____

WITNESS(ES)

(1) _____ (____) ____-_____
NAME ADDRESS PHONE

(2) _____ (____) ____-_____
NAME ADDRESS PHONE

PERSON COMPLETING FORM

_____
NAME TITLE ADDRESS

Owner Operator or Manager to submit this report when sending Medical Bills to Sedgwick, Attn: Chuck Eastwood. Fax # 210-332-1590