

**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**