RISK TRANSFER (PROGRAM 023717) WORKERS COMPENSATION REPORTING FORM

Dial **1-888-599-8726 or**
Fax to **1-678-937-8210**
E-mail to **risktransfer@choosebroadspire.com**

(*) Indicates a Mandatory Field. **IS THIS AN EMERGENCY CLAIM?** **YES** **NO**

***REPORTED BY PERSON'S NAME/PEO NAME**					
***TITLE:**		***BUSINESS PHONE:**		**EXT:**	
FAX NUMBER:		**E-MAIL ADDRESS:**			
***DATE OF ACCIDENT: MM/DD/YYYY**		***TIME OF ACCIDENT: (HH:MM AM/PM)**			
A. POLICY HOLDER INFORMATION					
***PROGRAM NAME**	RISK TRANSFER ([PROGRAM 023717)	***INSURED NAME**	Allstaff Payroll Inc.		
***ADDRESS:**	2101 N. 9th Avenue				
***CITY, STATE, ZIP:**	Pensacola, FL 32503		***COUNTY:**	Escambia	
***BUSINESS PHONE:**	850-434-6708	**EXT.**	**FAX NUMBER:**	**850-378-5232**	
***FEDERAL ID NUMBER:**		***POLICY NUMBER**			
B. CLIENT COMPANY					
***CLIENT COMPANY**					
***ADDRESS:**					
***CITY, STATE, ZIP:**			***COUNTY:**		
***BUSINESS PHONE:**		**EXT.**	**FAX NUMBER:**		
***FEDERAL ID NUMBER:**		**SIC CODE:**			
***LOCATION CODE:**		***NATURE OF BUSINESS**			
C. LOSS LOCATION INFORMATION					
***DID ACCIDENT OCCUR ON THE CLIENT COMPANY PREMISES? (X)**	**YES**		**NO**		
***LOCATION NAME:**					
***IF NO, ENTER PHYSICAL ADDRESS:**					
***CITY, STATE, ZIP:**			***COUNTY:**		
D. INSURED CONTACT INFORMATION					
***WOULD YOU LIKE TO BE THE CONTACT PERSON?: (X)**	**YES**		**NO**		
***** **IF NO, ENTER CONTACT PERSON NAME:**			**TITLE:**		
***ADDRESS:**					
***CITY, STATE, ZIP:**			***COUNTY:**		
CONTACT PHONE:		**E-MAIL ADDRESS:**			
E. INJURED WORKER INFORMATION					
***SOCIAL SECURITY NUMBER:**		***INJURED WORKER:**			
***ADDRESS:**					
***CITY, STATE, ZIP:**			**COUNTY:**		
RESIDENCE PHONE:		**BUSINESS PHONE:**		**EXT:**	
INJURED WORKER EMAIL ADDRESS:					
BIRTHDATE: MO/DAY/YR		***GENDER:(X)**	**FEMALE**		**MALE**
NUMBER OF DEPENDENTS:		**** MARITIAL STATUS:**			
***REGULAR OCCUPATION:**		***REGULAR DEPARTMENT:**		**CLASS CODE:**	
DATE OF HIRE: MM/DD/YY		**HIRE STATE:**		**STATE HIRE DATE: MM/DD/YY**	
SUPERVISOR NAME:					
SUPERVISOR EMAIL ADDRESS:					
EMPLOYMENT STATUS: (Full/Part Time)					
***GROSS WAGES: (Based on Pay Type)**					
HOURS WORKED PER DAY?		**DAYS WORKED PER WEEK?**		**HOURS PER WEEK?**	

(*) indicates a Mandatory Field

F. LOSS INFORMATION							
INJURED WORKER START TIME: (HH:MM AM/PM)			* DATE EMPLOYER NOTIFIED: (MM/DD/YY)				
* QUESTIONABLE CASE?	YES		NO				
* DESCRIPTION OF ACCIDENT:							
* REMOVED BY AMBULANCE? (X)	YES		NO		UNKNOWN		
* ANY STITCHES/SURGERY REQUIRED? (X)	YES		NO				
* WAS A FATALITY INVOLVED? (X)	YES		DATE		NO		
* DESCRIBE INJURY OR ILLNESS:							
* BODY PART INJURED?:		INDICATE RIGHT/LEFT/UPPER/LOWER BODY:					
* WORK PROCESS INJURED WAS DOING?							
* DIRECT CAUSE: (X)	SPECIFIC INJURY:		OCCUPATIONAL DISEASE OR CUMULATIVE INJURY :				
*SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?: (Y/N/U)			*SAFEGUARDS OR SAFETY EQUIPMENT UTILIZED?: (Y/N/U)				
*INJURED WORKER ON RESTRICTED DUTY? (X)	YES		NO		UNKNOWN		
* FULL PAY FOR DAY OF INJURY?	YES		NO		UNKNOWN		
* ANY LOST TIME? (X)	YES		NO		UNDETERMINED		
LAST DAY WORKED: MM/DD/YY			START DATE OF DISABILITY:				
DATE RETURNED TO WORK: MM/DD/YY		EXPECTED RETURN TO WORK: MM/DD/YY					
* SALARY CONTINUED DURING DISABILITY?	YES		NO		UNKNOWN		

G. MEDICAL INFORMATION					
* INITIAL TREATMENT? (X) ONLY SELECT ONE	* NO MEDICAL TREATMENT		* MINOR BY EMPLOYER		
	* MINOR HOSP/CLINIC		* EMERGENCY CARE		
	* HOSPITALIZED 24 HRS		* FUTURE MEDICAL/LOST TIME		
	* UNKNOWN				
* INJURED WORKER HOSPITALIZED OVERNIGHT AS INPATIENT?	YES		NO		UNKNOWN

PHYSICIAN		HOSPITAL INFORMATION	
* NAME:		* NAME:	
ADDRESS:		ADDRESS:	
CITY, STATE, ZIP:		CITY, STATE, ZIP:	
BUSINESS PHONE:		BUSINESS PHONE:	

H. WITNESS INFORMATION			
* NAME:		* NAME:	
ADDRESS:		ADDRESS:	
CITY, STATE, ZIP:		CITY, STATE, ZIP:	
PHONE:		PHONE:	

I. GENERAL REMARKS/COMMENTS	
GENERAL REMARKS:	

(*) indicates a Mandatory Field