EMPLOYEE INCIDENT STATEMENT

THIS IS NOT A REPORT OF INJURY FORM. PLEASE REPORT THE INJURY ONLINE AT WWW.MEM-INS.COM OR BY CALLING 1-800-442-0593.

NAME OF INJURED EMPLOYEE	DATE OF INCIDENT	TIME OF INCIDENT _____ ❒ A.M. ❒ P.M.	DATE REPORTED
DEPARTMENT		JOB TITLE	HIRE DATE
JOB PERFORMED		SUPERVISOR	
EMPLOYER		EMPLOYER POLICY NO.	
EMPLOYER CONTACT NAME		EMPLOYER TELEPHONE NUMBER	
INCIDENT LOCATION			
EXTENT OF INJURY ❒ NO INJURY ❒ FIRST AID ONLY ❒ TAKEN TO CLINIC ❒ TAKEN TO ER ❒ FATALITY		TREATING MEDICAL FACILITY	
BODY PART INJURED			
DESCRIPTION OF INCIDENT			
ANY OTHER WITNESSES? ❒ YES ❒ NO	NAME	NAME	NAME
WERE THERE OTHERS INJURED? ❒ YES ❒ NO	NAME	NAME	NAME
REPORT COMPLETED BY	SIGNATURE	DATE	
TITLE	PHONE NUMBER		

Fax or mail completed form to:

Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1-800-442-0597