	WORKERS' COMPENSATION CLAIM REPORTING CHECKLIST	3540 E. Broad St. Store 6870 #126 Mansfield, Tx 76063 Phone 214-888-6776 Fax: 1 214 833 7257 Email: claims@stratfocusllc.com

If employee is involved in an Auto Accident, complete this form in addition to Incident Reports.
Email the completed forms and to claims@stratfocusllc.com Fax to: 214 833 7257

Name of Employee:	SSN# (Last 4 digits):
Date of Accident:	Time of Accident: ☐AM ☐PM
Address/Intersection of Accident:	
Address Employee was going to:	
Address Employee was coming from:	
Did the Employee sustain any injuries in this accident? ☐Yes ☐No *If Yes, please list injuries below:*	
Did the Employee complain of pain after this accident? ☐Yes ☐No *If Yes, please list body parts below:*	
Type of Injury: *(e.g., bruise, cut, fracture, strain, sprain)*	
Body Part(s) injured: *(e.g., left eye, right forearm, right hand, left lower back)*	
Was Employee transported to Hospital by Ambulance? ☐Yes ☐No	

AUTO ACCIDENT INFORMATION

Describe the extent of damage sustained to the vehicle and where:	
Was a Police Report Filed? ☐Yes ☐No	Who was the Police Dept. or Responding Agency?
Was Employee considered "at fault" in this accident? ☐Yes ☐No	
Did the employee receive a citation due to this accident? ☐Yes ☐No	
Was Employee wearing his/her seatbelt? ☐Yes ☐No ☐Unknown	

In addition, please also forward the following to Strategic Focus:

- **Employee's Written Statement of the accident in detail**
- **Copy of the Driver Information Exchange and Police Report**

PRINT MANAGER NAME	CONTACT PHONE NUMBER	DATE COMPLETED