Employee Incident/Injury report

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.

TO BE COMPLETED BY EMPLOYER

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		MEM 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	

TO BE COMPLETED BY INJURED EMPLOYEE IF POSSIBLE

Body part injured			
Description of Incident			
Any other witnesses? ❒ Yes ❒ No	Name and Phone No.	Name and Phone No.	Name and Phone No.
Were there others injured? ❒ Yes ❒ No	Name and Phone No.	Name and Phone No.	Name and Phone No.

Report Completed by	Signature	Date
Title	Phone Number	

Submit completed form to:

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

Fax: 1.800.442.0597

Email: claims@mem-ins.com

Please complete the diagram on reverse side.