THE SANDNER GROUP™
Claims Management

155 North Wacker ■ Suite 3700 ■ Chicago, IL 60606-1731

Defining Insurance ■ Redefining Service

SandnerGroup.com

INJURED WORKER'S REPORT OF INJURY

Please complete and have your employer report the accident immediately to:
The Sandner Group· Claims Management

(Please Print or Type)

Employer:

Address:

Supervisor:

Employee Name:

Employee Address:

Employee Phone #: **Social Security #:**

Dependent(s) Names and Ages:

Occupation:

Date of Hire: **Other Employment:**

Date of Injury: **Time:** **Place:**

Witness(s): **Witness(s):**

Nature of Injury/Body Part Injured:

Last Day Worked: **Expected Return to Work Date:**

Treating Clinic:

How Did Accident Happen?

Date: _____ **Signature of Employee:** _____