FORM PECD 1
EMPLOYEE'S REPORT OF ACCIDENT

v. 6-22-2009

PUBLIC EMPLOYEE CLAIMS DIVISION
Arkansas Insurance Department
1200 West Third, Suite 201 – Little Rock, Arkansas 72201-1904
Telephone 501-371-2700 Facsimile 501-371-2733

TO BE COMPLETED BY EMPLOYEE

Name: _____ Tel # _____

Address: _____

Birth Date: _____ Marital Status: _____ Spouse's name: _____

Dependents Names and Ages: _____

Education (Circle highest level completed) 1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4 5+

Present employer: _____

Job title: _____ Length of employment: _____

If less than 5 years, list employers of last 5 years: _____

_____

Date of Accident: _____ Time: _____ Place: _____

Describe activity of employment engaged in at the time of injury: _____

_____

Describe how injury occurred: _____

_____

_____

To whom did you report the injury: _____

When: _____ Supervisor's name: _____

Nature and location of injury (describe part of body): _____

Doctor's Name: _____ Family Doctor's Name: _____

Who selected Doctor? _____ Are you still under doctor's treatment? _____

Date of first visit: _____ First day unable to work: _____

Have you ever collected compensation for a prior injury?_____

If yes, give details: _____

_____

Have you ever injured this part of the body before? ____Yes ___ No. If yes, give details including date:

_____

Do you have child support obligations? ___ Yes ___ No Child support obligation questions are required by Ark. law

If yes, are the obligations current or past due? ___ Current or ___ Past Due

To whom are the child support obligations payable? _____

Are you enrolled in the Medicare Program? ___ Yes ____ No The Medicare question is required by federal law.

Have you applied for Social Security Disability? ___ Yes ___No Date Applied for Social Security _____

If you applied for social security disability, was your claim approved or denied? ___ Approved ___Denied

Signed: _____ Date: _____