MOHAWK SELF INSURANCE

MSI-2 EMPLOYERS FORM

To be completed by employer/business owner/immediate supervisor

1) WORKER INFORMATION

☐ Non-recordable Injury

Worker Name
Address:
Postal Code:_____Telephone #:_____(_____)
Date of Birth:

2) Employer Information to be completed by immediate supervisor

Employer Name:
Employer Contact Person:
Address:
Postal Code:_____Telephone #:_____(_____)
Does your company have 20 or more workers/employees? ☐ Yes ☐ No

3) Accident/Illness Details to be completed by immediate supervisor

Date and Hour of Accident/Awareness of Illness:	Who was the Accident Reported to: Name and Telephone #
Date and Hour Reported to Employer:	Were there any witnesses to the accident? If so, please provide contact name and telephone #.
Describe what happened to cause the accident/illness and what the worker was doing at the time. Include what the injury is and any details of equipment, materials, environmental condition that may have contributed (attach additional page if required)	

4) WORKER DATA: to be completed by immediate supervisor

Trade or Profession at time of Accident:_____

EMPLOYEE STATUS *(Check one box)*

Permanent full time:	Contract part-time:	Permanent part-time:
Contract full-time:	Permanent seasonal:	Sub-Supplier?

Number of Years and Months at current position: Years:_____Months:_____

Does worker have other insurance coverage?_____yes_____no (if yes name, address and phone of other insurance coverage.

If yes Contact person:_____Phone number:_____

Effective date of worker's coverage:_____

Date worker ceased work because of accident:_____

Was worker regularly employed and working for you when disability began?yes_____no:_____

Is this being reported under workmen's compensation (CSST) yes_____no:_____

Salary at commencement of disability:__$_____hourly_____weekly_____monthly_____

If hourly, how many hours per week?_____

Official Position of Employer: (title):_Please Print_____

5) Lost Time – No Lost Time to be completed by immediate supervisor

Please choose one of the following indicators. After the day of the accident/awareness of illness, this worker:

☐ Returned to hi/her regular job and **has not** lost any time and/or earning

☐ Returned to **modified work** and **has not** lost any time and/or earnings

☐ **Has** lost time and/or earnings. Provide date worker first lost time _____

Date worker returned to work (if known) _____ ☐ Regular Work ☐ Modified Work

6) Return to Work to be completed by immediate supervisor

Have you been provided with work limitations for this worker's Injury? ☐ Yes ☐ No	Has modified work been discussed with this worker? ☐ Yes ☐ No
Have Modified Work been offered to this worker? ☐ Yes ☐ No If yes, was it ☐ Accepted ☐ Declined	Who is responsible for arranging worker's return to work.? ☐ Myself ☐ Other _____ Name _____ Phone #

Signature of **WORKER**:_____Date:_____

Signature of **Employer**:_____Date:_____

M.S.I. reserves the right to bring action to recover any benefits paid to an injured employee resulting from an accident caused by a third party. The beneficiary accepts to transfer all his/her rights to recover and authorize M.S.I. to enforce such rights in his/her name.

I hereby authorize the release to MSI any information requested in respect of this claim.