MOHAWK
SELF INSURANCE

MSI-2 EMPLOYERS FORM

To be completed by employer/business owner/immediate supervisor

1) WORKER INFORMATION

☑ Non-recordable Injury

Worker Name	Jane Smith
Address:	P.O. Box 123
Postal Code: JOL 1BO	Telephone #: 450 (635-0000)
Date of Birth:	January 1, 1982

2) Employer Information to be completed by immediate supervisor

Employer Name:	ABC Printing
Employer Contact Person:	John Doe
Address:	P.O. Box 456 Kahnawake
Postal Code: JOL 1BO	Telephone #: 450 (638-1010)
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: 8:00 am October 1, 2010	Who was the Accident Reported to: Name and Telephone # John Doe 450-6381010
Date and Hour Reported to Employer: 8:10 a.m. October 1, 2010	Were there any witnesses to the accident? If so, please provide contact name and telephone #. No witnesses

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)

Employee was passing paper through the cutter and was cut by the blade on her index finger of her right hand.

She reported the injury and cleaned it using our first aid kit, She did not go to the hospital.

4) WORKER DATA: to be completed by immediate supervisor

Trade or Profession at time of Accident: Paper Cutter Machine operator.

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: 3 Months: 4

Does worker have other insurance coverage? _____ yes X no (if yes name, address and phone of other insurance coverage.

If yes Contact person: _____ Phone number: _____

Effective date of worker's coverage: June 2007

Date worker ceased work because of accident: October 1, 2010

Was worker regularly employed and working for you when disability began? yes ✓ no: _____

Is this being reported under workmen's compensation (CSST) yes _____ no: X

Salary at commencement of disability: $ 800.00 hourly $20.00 weekly $800.00 monthly $3,200.00 or $4,000.00

If hourly, how many hours per week? 40 hrs

Official Position of Employer: (title): Please Print Owner

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**: Jane Smith Date: Oct. 1/10

Signature of **Employer**: John Doe Date: Oct. 1, 2010

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.