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STATE OF MISSOURI
OFFICE OF ADMINISTRATION
RISK MANAGEMENT SECTION

EMPLOYEE INJURY REPORT – WORKERS' COMPENSATION

CENTRAL ACCIDENT REPORTING OFFICE (CARO)
P.O. BOX 809
JEFFERSON CITY, MO 65102
573-751-2837
TOLL FREE 1-888-622-7694
FAX 573-526-0820

EMPLOYEE NAME	CARO NUMBER

We understand you may have suffered an injury or illness which may be compensable under the Missouri Workers' Compensation Law. In an effort to consider you for benefits under workers' compensation, you are asked to complete this injury report form. **Please complete the report in detail and do not leave any blanks.** Return immediately to your employer or to the Central Accident Reporting Office. Questions? Call 573/751-2837.

1. DATE OF INJURY	2. TIME OF INJURY

3. DESCRIBE CLEARLY AND IN DETAIL HOW YOU WERE INJURED. (INCLUDE LOCATION OF INJURY)

4. WHAT PART OF YOUR BODY WAS INJURED? (BE SPECIFIC - EXAMPLE RIGHT OR LEFT WRIST)

5. HAVE YOU RECEIVED TREATMENT TO THIS PART OF BODY PRIOR TO THIS ALLEGED INJURY? IF SO, PLEASE PROVIDE NAMES/ADDRESSES OF ANY PHYSICIANS YOU HAVE SEEN.

6. WERE ANY OTHER PARTS OF YOUR BODY INJURED?

7. NAME ALL WITNESSES TO YOUR INJURY.

8. WHO DID YOU REPORT YOUR INJURY TO?

9. WHEN DID YOU REPORT YOUR INJURY? GIVE DATE AND TIME

10. WHO REFERRED YOU TO MEDICAL TREATMENT OUTSIDE YOUR AGENCY OR FACILITY?

11. EXPLAIN ANY DELAYS IN REPORTING YOUR INJURY OR SEEKING MEDICAL TREATMENT.

12. IN YOUR OPINION, HOW MIGHT THE INJURY BE PREVENTED OR AVOIDED IN THE FUTURE?

I HAVE PREPARED AND READ THE ABOVE AND DECLARE IT TO BE TRUE.

SIGNATURE	DATE

ADDRESS	CITY/STATE	ZIP