PENSER North America, Inc.

1802 Terminal Drive ■ Richland, WA 99354 ■ Phone 509-420-7290 ■ Fax 509-420-7289

Employee Application for Injury or Occupational Disease Form
(Please complete the form below in its entirety)

APPLICANT INFORMATION

Emp. Name: _____ Mailing Address: _____
Phone/Cell: _____ Email: _____
Date of Birth: _____ S.S.N #: _____
Dependent(s) &
Marital Status: _____ DOB: _____
Dependent(s) & Dependent(s) &
DOB: _____ DOB: _____

EMPLOYMENT

Department: _____ Job Title: _____
Date of Hire: _____ Hourly Wage: _____
Work Schedule: _____ Work Hours: _____
Did you lose any time from work beyond date of injury / accident? (Yes) (No)

Last Day Worked: _____/_____/_____ | Date Returned to Work: _____/_____/_____

INJURY / ACCIDENT REPORT

Incident Date: _____ Incident Time: _____:_____ (A.M.) / (P.M.)
Incident Location: _____ Bodily Injury Location(s): _____
* Injury /accident was reported to Immediate Supervisor on (DATE) : _____/_____/_____
1.) Were you performing job duties? (Yes) (No) – Provide detailed description below.
2.) Was the incident the fault of another employee? (Yes) (No) | Name(s): _____
List any witnesses:
Part of body injured or exposed: Right ☐ Left ☐
Describe in detail how your injury occurred:

_____
_____
_____
_____

MEDICAL

Please complete this section if you received medical treatment for injury / accident

Physician Name/Clinic Name: _____
Address: _____
Phone: _____
Next follow up appointment/referred to: _____

Employee Signature: _____ **Date**: _____

DISCLAIMER & SIGNATAURE

I declare that the foregoing information & statement supplied are true to the best of my knowledge.
Medical Release Authorization: I hereby authorize my physician, hospital, agency, or organization to disclose to my employer or their representatives, any medical records or other information regarding treatment which has previously been furnished to me. NOTICE: Indian reservations are sovereign nations and are not subject to the state or federal workers' compensation laws. By completion of this form you are submitting to the sole jurisdiction of the tribe. NOTICE: Making or causing to be made any knowingly false or fraudulent material statement written or oral, or purposefully withholding material information in order to receive compensation is unlawful and will result in a denial of benefits, penalties, and/or prosecution.

Employee Signature: _____ **Date**: _____

IMMEDIATE SUPERVISOR SIGNATAURE

Supervisors Signature: _____ **Date**: _____

COLVILLE CONFEDERATED TRIBES WORKERS COMPENSATION

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