FORM PECD 1

EMPLOYEE'S REPORT OF ACCIDENT

9/2002

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: _____

Dependent's 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 time of injury: _____

_____

Describe how accident happened: _____

_____

Who did you report accident to: _____

When: _____ Supervisor's name: _____

Who witnessed or had first knowledge of accident? _____

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

_____

Doctor's name: _____ Family Doctor 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 had any other condition or injury involving this part of your body prior to this injury? _____

If yes, give details: _____

_____

_____

Do you have child support obligations? ☐ YES ☐ NO Child support obligation questions are required by Ark. Code Ann. 11-9-115.

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

To whom are the child support obligations payable? _____

Signed: _____ Date: _____