

**DALLAS NATIONAL INSURANCE COMPANY (DNIC)**  
**EMPLOYEE INCIDENT REPORT**  
**COMPLETE ALL BLANKS**

Date & Time of injury \_\_\_\_\_

Name of injured worker \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date of Hire \_\_\_\_\_

Injury reported to: \_\_\_\_\_

Client where incident occurred \_\_\_\_\_

Address where incident occurred \_\_\_\_\_

SSN \_\_\_\_\_

Home Phone \_\_\_\_\_

Marital Status \_\_\_\_\_ #Dependents \_\_\_\_\_

Weekly wages \_\_\_\_\_

Date injury reported \_\_\_\_\_

Describe the incident in detail (how, why, where, what) \_\_\_\_\_

Type of injury (cut, sprain, bruise, fracture, etc.) \_\_\_\_\_

Which part of body injured (be specific) \_\_\_\_\_

Are there any safety issues that contributed to this injury? If so, please detail: \_\_\_\_\_

List all witnesses to this incident: \_\_\_\_\_

List all prior injuries sustained at work and outside of work in the last 10 years that required medical attention (list body parts and dates): \_\_\_\_\_

I, employee, the undersigned, certify that the above is a true and correct statement of fact and that I made such statements of my own free will. I understand that any payments to me or anyone else for expenses in connection with my accident and resulting injury is not an admission of liability on the part of **DNIC**. I authorize full access to copies of medical records, radiology reports, drug/alcohol screenings, and documents of any kind relating to my past or present injury/illness to **DNIC**. I hereby agree to release this information and hold all such medical providers harmless for the release of this information as set forth in this authorization. **“Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.”**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE OF REPORT

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
TRANSLATED by (if necessary)

DNIC will prosecute to the fullest jurisdictional extent for all fraudulent claims reported.  
Per employment policy, a drug test is mandatory on all reported claims.

**PLEASE FAX TO:**

***'CbYGci fW'6 i gjbYgg'Gc`i Hcbg. 'ff +, £- - \$!, \* ' &***

**DALLAS NATIONAL INSURANCE COMPANY (DNIC)**  
**SUPERVISOR'S REPORT OF ACCIDENT**  
**PLEASE COMPLETE ALL BLANKS**

Date of this report \_\_\_\_\_ Date & Time of injury \_\_\_\_\_

Name of injured worker \_\_\_\_\_ SS# \_\_\_\_\_

Date of hire \_\_\_\_\_ Date employee reported incident \_\_\_\_\_

Employee occupation \_\_\_\_\_ Hire date \_\_\_\_\_ Time of incident \_\_\_\_\_

Person employee reported incident to: \_\_\_\_\_

Client where incident occurred \_\_\_\_\_

Address where incident occurred \_\_\_\_\_

Has employee lost time from work? (If yes, give dates of lost time and if employee has returned to work) \_\_\_\_\_

Describe the incident in detail (how, why, where, what) \_\_\_\_\_

Is a third party (another company or individual) responsible for this incident? If yes, please detail \_\_\_\_\_

Type of injury (cut, sprain, bruise, fracture, etc.) \_\_\_\_\_

Which part of body injured (be specific) \_\_\_\_\_

Are there any safety issues that contributed to this injury? If so, please detail: \_\_\_\_\_

List all witnesses to this incident: \_\_\_\_\_

Name of Medical facility where employee taken \_\_\_\_\_

Phone # and address of medical provider \_\_\_\_\_

Do you know, or have you heard, any information regarding this incident that **DNIC** should know? \_\_\_\_\_

Supervisor or Foreman completing this report: \_\_\_\_\_

Please print name and phone #

Signature \_\_\_\_\_

**\*\*\*\*REPORT DUE WITHIN 24 HOURS OF ACCIDENT\*\*\*\***

**\*Please ensure that the Employee Incident Report and Witness Statement Report are completed\***

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**CB9GCI F79'6I G-B9GG'GC @ HCBG--(\*+,) -- \$-, \*' &**

**DALLAS NATIONAL INSURANCE COMPANY (DNIC)**

**WITNESS STATEMENT**

**PLEASE COMPLETE ALL BLANKS**

**Name of Witness** \_\_\_\_\_ **Date of this report** \_\_\_\_\_  
**Employed by** \_\_\_\_\_

**Name of injured worker** \_\_\_\_\_  
**Date & Time of injury** \_\_\_\_\_  
**Client where incident occurred** \_\_\_\_\_  
**Address where incident occurred** \_\_\_\_\_

**Are you related to the injured worker?** \_\_\_\_\_  
**How long have you known the injured worker?** \_\_\_\_\_

**DID you actually see the incident?** \_\_\_\_\_  
**Explain, in detail, what you saw or know regarding this incident:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List names of any other persons who may have information regarding this incident:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Is there any other information that you know that would assist in providing a fair evaluation of this incident?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Print name** \_\_\_\_\_ **Signature** \_\_\_\_\_  
**Phone #:** \_\_\_\_\_

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