

**THE UNIVERSITY OF ALABAMA IN HUNTSVILLE**  
**EMPLOYEE OCCUPATIONAL INJURY CLAIM**

**General Information**

Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Work Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Health Insurance Carrier: \_\_\_\_\_  
Health Insurance Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Were claims filed with your health insurance provider for all eligible expenses for the treatment of the injuries sustained? \_\_\_\_\_ Yes \_\_\_\_\_ No Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

**Accident Information**

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ : \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.  
Location of Accident: \_\_\_\_\_  
Witnesses to Accident: \_\_\_\_\_  
Activity engaged in when accident occurred: \_\_\_\_\_  
Summarize how accident occurred: \_\_\_\_\_  
Injuries sustained in the accident: \_\_\_\_\_

**Medical Treatment Information**

Date you first obtained medical assistance for the injuries sustained: \_\_\_\_\_  
Names and locations of medical facilities from which you obtained medical assistance (Physician/Clinic/Hospital):  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_  
Were any orthotics or prosthetics prescribed for the injuries sustained? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Name and location of orthotics and/or prosthetics provider: \_\_\_\_\_  
Were any pharmaceutical expenses accrued due to the injuries sustained? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Pharmacy and location used to fill prescriptions: \_\_\_\_\_

**Work Absence - Election**

Did your injuries cause you to be absent from work? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Do you wish to charge the time absent from work to: \_\_\_\_\_ Annual Leave \_\_\_\_\_ Sick Leave \_\_\_\_\_ Lost Wage Benefits  
**(Lost Wage Benefits equate to 66 2/3 of your regular salary)**

*I hereby certify that the facts and circumstances stated above regarding my occupational injury are true and correct to the best of my knowledge and that all medical and drug expenses for which I am claiming reimbursements were incurred by me in connection with treatment of such injury.*

Claimant: \_\_\_\_\_ Date: \_\_\_\_\_

STATE OF ALABAMA            )  
  )  
MADISON COUNTY            )

Sworn to before me and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC  
MY COMMISSION EXPIRES: \_\_\_\_\_