

EMPLOYEE'S REPORT OF CLAIM
 Michigan Department of Licensing and Regulatory Affairs
 Workers' Compensation Agency
 P.O. Box 30016, Lansing, MI 48909

NOTE: A copy of this form will be sent to your employer and their workers' compensation insurance carrier. Do not submit any medical reports with this form.

1. Social Security Number	2. Date of Injury	3. Date of Birth (MM/DD/YYYY)	4. Employee Telephone Number
5. Employee Name (Last, First, MI)		10. Employer Name	
6. Employee Street Address		11. Employer Street Address	
7. Employee City	8. State	9. ZIP Code	12. Employer City
			13. State
			14. ZIP Code
15. Describe the type of injury and explain how it happened.			
16. Are you making a claim for payment of medical expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. Last Day Worked	
18. Have you gone back to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of return _____		19. Was the injury reported to your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date reported _____	

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

20. Employee Signature	21. Date of this report
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OFFICE USE ONLY

Carrier Name

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.	Authority: Workers' Disability Compensation Act, 408.31(4) Completion: Voluntary Penalty: None
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