MOHAWK SELF INSURANCE

Workers Claim Report MSI-1

Incident report only yes no	
Worker first name: Gender: M F	RAMQ number:
Worker last name:	Social Insurance Number
Street or P.O. Box: City: Province: Postal Code:	Date of injury: Month Day Year Time of Injury:
Home telephone #:	Date of Birth: Month Day Year
Cellular #:	Occupation of worker:
Employer Address: Street or P.O. Box: City: Province: Postal Code: Employer telephone	Employer name: Employer contact (person's name): Place of injury:

Describe the injury and how it happened:

Is this a reaggravation of a previous injury?	Yes:		No:	
Did you stop working the day of the injury?	Yes:		No:	
What were your wages at time of injury?	Hourly:		Weekly:	
Do you have more than one job?	Yes:		No:	
Has this injury been reported to any other agency?	Yes:		No:	

Worker Declaration

I declare that the information provided in this claim is true and complete.

Signature of worker _____

Date (M/D/Y): _____

Authorization to collect information regarding my state of health.

I authorize any physician or health professional, health worker, healthcare or social services institution or clinic to release information concerning my state of health to Mohawk Self Insurance and its representatives for the purpose of processing my claim. Subject to express revocation in writing by me, this authorization remains valid until this claim has been fully processed.

Signature of worker granting Authorization: _____