MOHAWK
SELF INSURANCE

Employers Report MSI-2

1) WORKER INFORMATION

☐ No Lost Time

Worker last Name:	Worker first name:

2) EMPLOYER INFORMATION (To be completed by immediate supervisor)

Employer Name:	Contact name:
Employer Address:	Telephone number: E-mail:
Date and Hour that accident/illness was reported to employer:	Name of person that accident was reported too:
Date that employee stopped working because of accident:	Please list the names of any witnesses to the accident:
Describe in detail what happened to cause the accident/illness, include what the injury is and any details of equipment, materials, environmental conditions that may have contributed (attach additional page if required). Use back of sheet if necessary.	

Salary of worker at time of the accident: Hourly $_____, Weekly $_____, Monthly $_____.

If hourly; how many hours per week? _____

Signature of representative completing this report
(Please print name):_____ **Date** (M/D/Y):_____

Signature of Employer: _____ **Date** (M/D/Y):_____

By signing above, I am declaring that all the information provided here is true and correct to the best of my knowledge. MSI reserves the right to bring action to recover any benefits paid to an injured worker resulting from an accident caused by third party. I hereby authorize the release to MSI any information requested in respect of this claim.