

**FORM PECD 1
EMPLOYEE'S REPORT OF ACCIDENT**

**PUBLIC EMPLOYEE CLAIMS DIVISION
Arkansas Insurance Department
1200 West Third, Little Rock, Arkansas 72201-1904
Telephone 501-371-2700 Facsimile 501-371-2733**

TO BE COMPLETED BY EMPLOYEE:

Name: _____ Tel # _____

Address: _____

Birth Date: _____ Marital Status: _____ Spouse's Name: _____

Dependents Names and Ages: _____

Education (Circle highest level completed) 1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4 5+

Present Employer: _____

Job Title: _____ Length of Employment: _____

If less than 5 years, list employers of last 5 years: _____

Date of Accident: _____ Time: _____ Place: _____

Describe activity of employment engaged in at time of injury: _____

Describe how injury occurred: _____

To whom did you report the injury: _____

When: _____ Supervisor's Name: _____

Nature and location of injury (describe part of body): _____

Doctor's Name: _____ Family Doctor's Name: _____

Who Selected Doctor? _____ Are you still under doctor's treatment? _____

Date of First Visit? _____ First Day Unable To Work? _____

Have you ever collected compensation for a prior injury? _____

If yes, give details: _____

Have you ever received medical or chiropractic treatment to this part of the body before (either as a workers' compensation or a non-workers' compensation injury)? ____ Yes ____ No. If yes, give details including date: _____

Do you have child support obligations? ____ Yes ____ No (Child support obligation questions are required by Ark. Law)

If yes, are the obligations current or past due? ____ Current or ____ Past Due

To whom are the child support obligations payable? _____

Are you enrolled in the Medicare Program? ____ Yes ____ No (Medicare question is required by federal law.)

Have you applied for Social Security Disability? ____ Yes ____ No Date Applied for Social Security _____

If you applied for social security disability, was your claim approved or denied? ____ Approved ____ Denied

Signed: _____ Date: _____