MAXCIS, INC.
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EMPLOYER'S INITIAL REPORT OF INJURY - MIOSHA 301

1. Social Security Number: _____ Case # from the Log: _____

2. Legal Name: _____ 3. Gender: _____

4. Address: _____ City: _____ State: _____ Zip: _____

5. Telephone # (Home): _____ (Cell): _____

6. Birth Date: _____ 7. Work Permit Required?: _____ 8. Marital Status: _____

9. Date of Hire: _____ 10. Department: _____ 11. Occupation: _____

12. Supervisor's Name: _____ 13. Time employee began work: _____ ☐ AM ☐ PM

14. Date of Injury: _____ 15. Time: _____ ☐ AM ☐ PM

16. Date reported to Employer: _____ 17. Time: _____ ☐ AM ☐ PM

18. To Whom Reported: _____

19. Last Day Worked: _____ 20. Date Returned to Work: _____

21. Brief Description of Accident and Injury **(BE SPECIFIC):**

_____

22. Name of witnesses: _____

23. If treatment was given away from the work site, where was it given? Facility: _____

24. Address: _____ City: _____ State: _____ Zip: _____

25. Date of ***FIRST*** Treatment: _____ 26. Was employee treated in an emergency room?: ☐ Yes ☐ No

27. Was employee hospitalized overnight as an in-patient?: ☐ Yes ☐ No

28. If the employee died, when did the death occur? Date of Death: _____

29. Injury Location: City: _____ County: _____ Zip: _____

30. Member Name: _____

31. Address: _____ City: _____ State: _____ Zip: _____

32. Contact Name: _____ Telephone #: _____

Please note that this form is housed on a secure website, however, ***if you wish to*** e-mail ***it to us, it is only as secure as your*** e-mail ***service.*** If you are concerned about security, you may send it to us via FAX.

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