FFVA MUTUAL
THE CHOICE FOR WORKERS' COMPENSATION

EMPLOYEE ACCIDENT/INJURY REPORT

Employer Information		
Company	Location	
Employee Information		
Employee Name	Job Title & Department	Date of Hire
Address	City, State, Zip	
SSN	DOB	
Accident Information		
Date and Time of Accident or Injury	Date and Time Reported to Employer	
Employee's Description of How Accident or Injury Occurred		
Description of Injury or Disease (be specific and include body part, noting right or left side and the injury sustained)		
Were There any Witnesses? Yes ☐ No ☐	If Yes, Name & Telephone (please attach separate signed statement)	
Home Address of Witness	City, State, Zip	
Name and Address of Medical Provider	Telephone	
Employee Signature	Date	
Employer Signature	Date	

Mail or fax this report to:
FFVA Mutual, PO Box 945927, Maitland, FL 32794-5927
Fax number (321) 214-0235

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program or files a statement of claim containing any false or misleading information can be guilty of committing a felony.