First Aid – Report Only

Please complete and return to LWP Claims Solutions, Inc.

Employer:_____

Employee Name	Social Security #
Address	City, State, Zip
Date of birth	Wages
Date of hire	Date of injury
Department	Occupation

Cause _____ Site _____ Nature _____ Agency _____

Description of Accident:

_____

_____

_____

_____

_____