Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION	N
Ark. Code Ann. §§11-9-701, 508, 514 AWCC Rule 099.33 Revised: 1-1-2001 Updated: 8-1-2006	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

EMPLOYEE'S NOTICE OF INJURY

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	M I	Social Security Number	Home Phone No.
Street Address or P.O. Box	City		State	Zip Code

Child Support Obligation: ☐ Current ☐ Past Due Payable to:

EMPLOYER INFORMATION (Please Print)

Employer's Name		Supervisor's Name	
Employer's Street Address or P.O. Box	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

Place of Accident	Date of Accident	Time of Accident	Date /Time Employer Notified of Accident

What part of your body was injured? _____

Briefly discuss the cause of injury: _____

Name/address of witness(es): _____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, written or oral, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change-of-physician. (See additional information on back side of form)

Date _____ Signature _____

Assistance with AWCC Form N is available from the AWCC Legal Advisor Division (1-800-250-2511 or 501-682-3930). Information is supplied by the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

ARKANSAS SUPPORT NETWORK, INC.
ACCIDENT/ INJURY REPORT

Name of Individual Completing Report: _____

Report Date: _____/_____/_____ Address of Incident: _____

Name(s) of Individual(s) Involved: _____

Witness to Accident/Injury: _____

When was the accident discovered: Date: _____/_____/_____ Time: _____AM _____PM

Location of Accident/Injury: _____

Explanation of Occurrence: _____

_____

_____

_____

_____

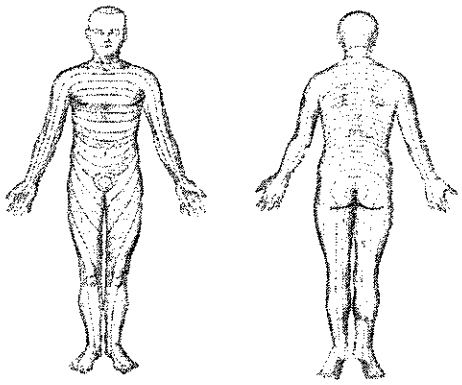
_____

Physical Injury: _____ Yes ___ No On- Call Administrator/Supervisor Notified: _____Yes____ No

Name of Individual Notified: _____

Description of the Injury: _____

Please Mark Injured Area:



Description of Treatment/Care: _____

Program Manager Notified: _____

Date: _____/_____/_____ Time: _____

Program Manger Reviewed Report On: _____/_____/_____

Signature: _____

Program Manager's Signature: _____