



PROUD TO SERVE THOSE WHO SERVE

## INCIDENT AND INJURY INFORMATION

Incident and Injury Request #1

*\*Please note that this request must be submitted by a first level supervisor or an H/R Supervisor.*

Today's Date: \_\_\_\_\_ Department / Agency: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Line of Duty Injury? ☐ Non-Line of Duty Injury? ☐

Name of Injured Individual: \_\_\_\_\_ Title / Position: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_

Is Injured Individual a Full-Time Paid Employee? Yes/No

Years of Service: \_\_\_\_\_

Describe Incident and Events of Injury:

*\*Please submit copy of Department Incident Report or Industrial Claim with request*

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In Hospital: YES/NO

ICU: YES/NO

Estimated Hospital Stay: \_\_\_\_\_

Estimated Time Off Work: \_\_\_\_\_

Does Injured Require Extensive or 24-Hour Care If Not in the Hospital? \_\_\_\_\_

Has Injured Individual Worked Any Hours Since Injury (Full Duty or Light Duty)? \_\_\_\_\_

Has Injured Individual Been Out Of Work For 30 Days Or More? \_\_\_\_\_

## BENEFICIARY INFORMATION

Beneficiary Name (Spouse / Parent): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Other: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

Make Benefit Check To: \_\_\_\_\_ Relationship to Injured: \_\_\_\_\_

Where Shall Payment Be Delivered?: \_\_\_\_\_

How Many Dependents (Other Than Spouse): \_\_\_\_\_

**Name, Sex, and Date of Birth of Dependents:**

*\*This information is used internally to provide opportunities to dependents such as: summer camp, holiday gift giving, scholarship opportunities, etc.*

1. Name: \_\_\_\_\_ Sex: \_\_\_\_ DOB: \_\_\_\_\_

2. Name: \_\_\_\_\_ Sex: \_\_\_\_ DOB: \_\_\_\_\_

3. Name: \_\_\_\_\_ Sex: \_\_\_\_ DOB: \_\_\_\_\_

4. Name: \_\_\_\_\_ Sex: \_\_\_\_ DOB: \_\_\_\_\_

5. Name: \_\_\_\_\_ Sex: \_\_\_\_ DOB: \_\_\_\_\_

*\*dependent is that which is adopted, biological, or of which the public safety individual has guardianship*

*\*if needed please continue information on separate document*

**INFORMATION PROVIDED BY**

*\*Must be submitted by a first level supervisor or an H/R Supervisor.*

Your Name: \_\_\_\_\_ Title: \_\_\_\_\_

Department/Agency: \_\_\_\_\_

Agency Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Other: \_\_\_\_\_

Email: \_\_\_\_\_

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Second Level Supervisor Name: \_\_\_\_\_ Title: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Department Head/Chief Name: \_\_\_\_\_ Email: \_\_\_\_\_

*Submit form by email, send to [contact@borderland100club.com](mailto:contact@borderland100club.com)*

**TO BE COMPLETED BY AUTHORIZED 100 CLUB PERSONNEL**

Verified/Approved: \_\_\_\_\_ Date: \_\_\_\_\_ Data ID: \_\_\_\_\_ Payment ID: \_\_\_\_\_

Posted: \_\_\_\_\_ Date: \_\_\_\_\_ Check #: \_\_\_\_\_ Amount: \_\_\_\_\_

Denied: \_\_\_\_\_ Date: \_\_\_\_\_