PECD 2 FORM
WORKER'S COMP INFORMATION SHEET
TO BE COMPLETED BY EMPLOYER ON EACH WORKERS COMPENSATION CLAIM
INFORMATION REQUESTED BY PUBLIC EMPLOYEE CLAIMS DIVISION

8/2007

1) Employer ____________________

2) Employee's Name ____________________ AASIS Employee ID No. __________

3) Injury Date ____ / ____ / ____ Date Disability Began ____ / ____ / ____

4) Has employee returned to work? __________ If so, date ____ / ____ / ____

5) Who selected initial treating physician? Employee Employer

6) Did employee's salary continue while off work?
If so, check source and indicate time period

☐ Sick Form ____ ____ / ____ Through ____ / ____ / ____
☐ Annual From ____ / ____ / ____ Through ____ / ____ / ____
☐ Other From ____ / ____ / ____ Through ____ / ____ / ____

7) Employer claim recommendation: Accept __________ - or - Deny__________

If recommendation is to deny, explain and attach extra page if needed:

____

____

8) Other employees injured in this accident ____________________

9) Checklist: First report of injury or illness (Form IA-1)

Employer Name & Address (Upper Left Hand Corner) ☐
Wage Information ☐ Date of Hire ☐
Date Disability Began ☐ Return to Work Force ☐
Contact Name/Phone Number (Whom we should call if we have questions) ☐
Specific activity & work process employee was engaged in when accident occurred. ☐
Witness (or person having immediate knowledge) ☐
Date prepared/signature/phone number ☐
Attach notes & bills from medical providers if available ☐

10) Have employee complete AR-N and refer to notices on the reverse side of the form. ☐

Name: ____________________ Title: ____________________ Date: __________

Phone: ____________________ Fax: ____________________