CONTACT LOG

It is the Supervisor’s responsibility to ensure this form is kept up-to-date and in the Claims Management File established for the injured worker.

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee Information** | | | |
| Injured Employee’s Name | | Injured Employee’s Phone Number | |
|  | |  | |
| Supervisor Name | | Supervisor Phone Number | |
|  | |  | |
| Injured Employee’s Title & Job Description | | | |
|  | | | |
| **Case Information** | | | |
| Return to Work Date | | Review Date | Target Date |
|  | |  |  |
| Treating Physician(s) | | Treating Physician’s Phone Number(s) | |
|  | |  | |
| Claim Number | | Claims Adjuster & Phone Number | |
|  | |  | |
| **Record of Contact** | | | |
| Date of Contact | Contents of Conversation | | |
|  |  | | |
|  |  | | |
|  |  | | |
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|  |  | | |

If necessary, attach another paper to record all contact with injured employee.