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 |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

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