MISSISSIPPI WORKERS' COMPENSATION COMMISSION

P. O. Box 5300
JACKSON, MISSISSIPPI 39216

EARLY NOTIFICATION OF SEVERE INJURY

Date of Injury ____________________

Employee's Name ____________________

Address ____________________ Home Telephone # ____________________

Employer ____________________

Address ____________________

Carrier ____________________

Name and Address of Hospital ____________________

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Name and Address of Physician ____________________

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Type of Injury: ☐ Major Amputation ☐ Spinal Cord Injury ☐ Brain Damage

☐ Loss of Sight, one or both eyes ☐ Severe Burns, 2nd° and 3rd°

☐ Other: explain ____________________

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Remarks ____________________

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Signed ____________________

Title ____________________

NOTICE: This notification must be filed with MWCC immediately.

THIS DOES NOT REPLACE B-3

Send this report directly to:

Mississippi Workers' Compensation Commission
P. O. Box 5300
Jackson, MS 39216

Attention: Rehabilitation Unit

MWCC Form R-1 (Adopted 7-82) (Color Code - White)

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