

# LOSS SUMMARY DATA REPORT - ITEMIZED LISTING

FOR PERIOD ENDING DECEMBER 31, 2006

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Name of Self-Insurer \_\_\_\_\_

AWCC FILE #	NAME OF EMPLOYEE	DATE OF ACCIDENT	NATURE OF INJURY	AMOUNTS PAID FOR			TOTAL PENDING RESERVES
				INDEMNITY	MEDICAL	EXPENSES	
<b>Do Not complete this form.</b>							
<b>This form is presented here for information purposes only.</b>							
<b>This form is generated by the Self- Insurance Division pre-printed with certain information specific to the self-insurer.</b>							