

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	
Do Not complete this form.							
This form is presented here for information purposes only.							
This form is generated by the Self- Insurance Division pre-printed with certain information specific to the self-insurer.							