Clear Form Print Form

Report of Injury

Please complete this form as accurately as possible. All questions must be answered <u>completely</u>. If you are unsure or have questions please seek clarification. Information contained in this form is very important.

Section I *Employee Information*		
NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH __/__/____	SOCIAL SECURITY NUMBER ___-__-____
ADDRESS	JOB TITLE	EMPLOYMENT STATUS (FT/PT)
PHONE ___-___-____	SEX/GENDER	DATE OF HIRE __/__/____

Section II *Incident Report*		
DATE OF INJURY __/__/____	TIME WORK BEGAN __:__ ○ AM ○ PM	TIME OF INJURY __:__ ○ AM ○ PM
NAME OF SUPERVISOR	DATE SUPERVISOR WAS NOTIFIED	DATE REPORT WAS PREPARED
LOCATION OF INCIDENT (SPECIFY)	EQUIPMENT/MATERIALS USED WHEN INCIDENT OCCURRED	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?
DESCRIBE NATURE OF INJURY IN DETAILS (INCLUDE BODY PART AFFECTED, i.e. FRACTURED LEFT ARM)		
DESCRIBE HOW THE INJURY OCCURRED. INCLUDE SEQUENCE OF EVENTS.		
DID EMPLOYEE LEAVE WORK EARLY DUE TO INJURY (IF YES, INCLUDE TIME EMPLOYEE LEFT)		
ADDITIONAL INFORMATION		
WITNESSES (NAME & PHONE NUMBER)		
PREPARER'S NAME, TITLE AND CONTACT INFORMATION		

Section III *Treatment Information*	
PHYSICIAN NAME AND ADDRESS	INITIAL TREATEMENT ☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR: CLINIC/HOSPITAL ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HOURS ☐ MAJOR MEDICAL/LOST TIME ANTICIPATED
HOSPITAL NAME AND ADDRESS	