Employee Injury Report to Employer Form

STATE AUTO Insurance Companies

RTW

NOTE: This is NOT the First Report of Injury!

INSTRUCTIONS: (1) Employee's Injury Report. Employee must notify their employer of any work-related injuries immediately. The injured employee and their supervisor completes Part 1 of this form. The supervisor (or safety representative) conducts investigation and completes Part 2 of this form. The form is provided to employer's workers' compensation manager (WCM). (2) First Report of Injury. The WCM completes the First Report of Injury (FROI) based on Employee's Injury Report (EIR) and any verbal clarification made by the injured employee. (3) Notifying RTW. WCM submits FROI and EIR to RTW. *** ***please print clearly*** ***

Company name:	

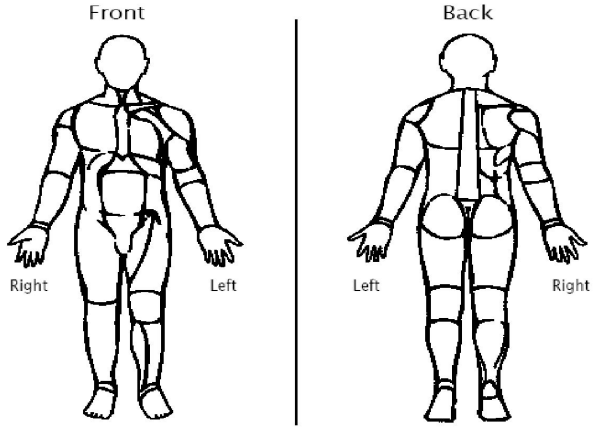
PART 1 - INJURED EMPLOYEE

Last name:		First name:		Middle initial:	
Home address:					
City:		State:		Zip Code:	Phone: ( )

Date of injury:		Day of Week:		Time of injury:	a.m.	p.m.
Date-time left work:		Date-time returned:		Lost time:	☐ yes	☐ no

Employee's explanation for injury:

Mark Areas of Injury Below



Name(s) of witness(es) to injury:

PART 2 - SUPERVISOR (OR PERSON CONDUCTING INVESTIGATION)

Name and Title:

Cause:

☐ Burn, Scald, Exposure, Contact Injury
☐ Caught In, Under, or Between
☐ Cut, Puncture, Scrape, Injured By
☐ Fall, Slip or Trip
☐ Motor Vehicle
☐ Repetitive Motion Injury
☐ Rubbed or Abraded By
☐ Strain or Injured By
☐ Striking Against or Stepping On
☐ Struck or Injured By (Kick, Stabbed, Bit)

Type of Injury:

☐ No apparent injury
☐ Amputation
☐ Burn
☐ Contusion
☐ Crushing
☐ Electrical Shock
☐ Cumulative trauma (repetitive motion)
☐ Foreign Body (e.g., in eye, etc.)
☐ Laceration/Cut
☐ Puncture (e.g. needlestick)
☐ Sprain / Strain
☐ Other: _____

Was there a:	**Findings/comments:**
☐ Safety Rule Violation *(explain)*:	
☐ Other Violation *(explain)*:	
☐ Machine Malfunction *(explain)*:	
☐ Motor Vehicle Accident	

What actions are being taken to prevent a recurrence:

Date-time supervisor notified:		Date-time accident report completed:	

Employee referred to:	☐ Designated Medical Provider *(specify):*	☐ Hospital Emergency Room *(specify):*	☐ Declines Medical Care at this Time

Supervisor's signature		**Date:**	
Employee's signature:		**Date:**	

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