EMPLOYEE'S REPORT OF INJURY

Injured Employee Completes

Employee:_____ Social Security #_____

Address:_____

Day Phone:_____ Evening Phone_____

Male____ Female ____ Age_____ Date of Birth _____ Occupation_____

Date of Incident_____ Time_____ AM or PM

Date Hired _____ Hour You Began Work _____

Location of Incident: Building:_____ Room # or Area _____

Description of Incident: (State whether you slipped, fell, were struck, etc. and what you were doing at the time of injury)_____

_____

_____

_____

STATE NATURE OF INJURY AND PART (S) OF BODY AFFECTED NO MATTER HOW MINOR (Specify Right or Left) (eg: if arm, specify exactly part of arm elbow, shoulder, forearm)

_____

_____

Names of
Witness(s)_____

Did you go to the hospital? Yes_____ No _____ Date_____

Hospital Name and Address_____

Name of Doctor_____

_____

Signature of Employee