

Today's Date: ___/___/___

EMPLOYEE REPORT OF INJURY
(To be filled out by injured employee)

EMPLOYEE INFORMATION

Your Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Marital Status: S ___ M ___ D ___ W ___

Date of Birth: ___/___/___ Children under 18: Y ___ N ___ If Yes, How Many: _____

Facility Name: _____

Job Title: _____ Department: _____

Other Employment: Employer's Name: _____

Type of Work: _____

INFORMATION ABOUT THE INCIDENT (be as specific as possible)

Date of Incident ___/___/___ Time of Incident _____ a.m./ p.m.

Where did Incident Occur? _____

What were you doing at the time of the incident? _____

What happened? _____

Property/Equipment Involved? _____

What could be done to prevent similar incidents in the future? _____

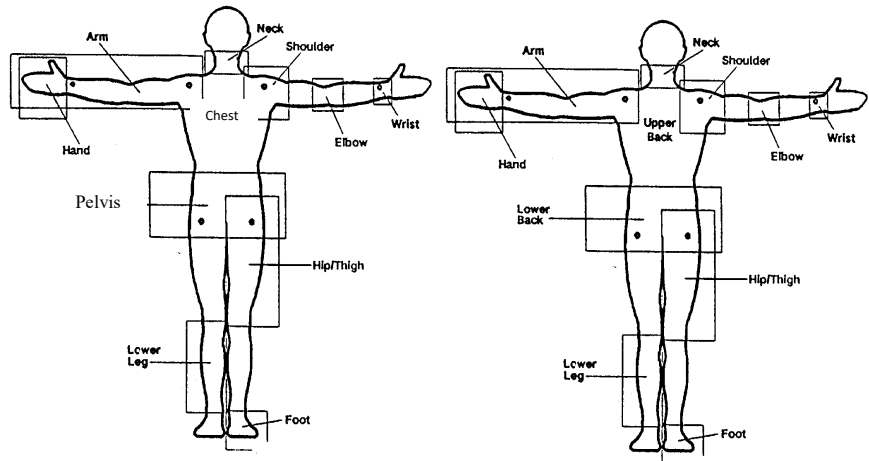
Witnesses, if any? Y ___ N ___ Witness Name(s): _____

To Whom did you report the injury? _____

Was any on site treatment received? If so, explain: _____

INFORMATION ABOUT THE INJURY

What part(s) of your body was injured? Please indicate on diagram:



Have you understood the questions you have answered? Yes / No

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____