☐ Not seeking medical attention at this time.

☐ Medical attention required.

Employees' Report of On-the-Job Injury

The injured employee must complete this form, not the employee's supervisor.

Date of Incident ____/____/____ Date Reported ____/____/____

Time of Injury ____:____ ☐AM ☐PM Time shift began ____:____ ☐AM ☐PM

Reported to? ________________ Supervisors Name ________________

Did you receive the Workers' Compensation Packet of information? ☐Yes ☐No

If there was a delay in reporting the injury, please explain the reason for the delay: ____________________________

Personal Information

Full Name ____________________________ Date of Birth ____/____/____

Mailing Address ____________________ City ____________ State ____ Zip ______

Telephone Number ______________ Preferred Email Address ________________

Employee # ______________ Job Title ______________ ☐Full Time ☐Part-time

Department ________________________ Date of Hire __________

Gender: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Other

Accident Information

Body part(s) injured ____________________________ ☐Left ☐Right ☐N/A

Did you/do you plan to go to a panel doctor? ☐Yes ☐No Where? ____________________

Accident Location - Be specific. Include the building, indoor/outdoor, side of building, room number, etc.

____

Provide a detailed description of how the accident/injury occurred. Attach additional pages if needed. Include what you were doing at the time of the injury, conditions, equipment being used, cause, etc.

____

Did you finish your shift on the day you were injured? ☐Yes ☐No

Safety Equipment Used ____________________

Any Witnesses?

Name(s) ________________ Relation ____________ Phone Number(s) ____________

Name(s) ________________ Relation ____________ Phone Number(s) ____________

I ________________(name) acknowledge that the above information is an accurate account of the work-related incident which occurred on ________(date). I understand that if want my medical costs to be covered by workers' compensation insurance, I must seek treatment at a provider listed on the Workers' Compensation Panel of Physicians (pink panels).

Employee Signature: ____________________________ **Date:** ____/____/____