REPORT OF WORK INJURY

SECTION I. EMPLOYER INFORMATION AND IDENTIFICATION

NAME:

ADDRESS:

CITY:

STATE:
ZIP CODE:

TELEPHONE NUMBER: ( )

SECTION II. EMPLOYEE INFORMATION

Did Employee: ☐ **Stay on Job** ☐ **Go Home** ☐ **See Physician** ☐ **Hospitalize** ☐ **Other** ☐ **Return to Restricted Work**

First Name: _____ **Init.** ____ **Last Name:** _____ **Social Security No.** _____

Employee's Usual Occupation: _____ **Occupation at Time of Accident (If different)** _____

Nature of Injury/Illness: _____ **Part of Body:** _____ **Object Involved:** __

Person(s) in Control of Object: _____ **First Aid Given by:** _____ **Attending Physician:** _____

Hospital/Address/Phone: _____

EMPLOYEE CATEGORY:

☐ **Regular Full Time** ☐ **119 Day** ☐ **Temporary Part Time**

☐ **Other (Describe)** _____

Length of Employment: _____ **Days/Mo/Yrs**
Time in Occupation at Time of Injury: _____ **Days/Months/Years**

SECTION III. ACCIDENT DESCRIPTION

LOCATION OF ACCIDENT: _____

_____

_____

DATE & TIME OF INJURY/ILLNESS: _____, 2002__ ___:___ **AM**__ **PM**__

Was an employee injured in the accident? ..... ☐ **Yes** ☐ **No**
Did the incident involve employee illness? ..... ☐ **Yes** ☐ **No**
Did the incident involve property damage? ..... ☐ **Yes** ☐ **No**
Was a motor vehicle involved? ..... ☐ **Yes** ☐ **No**
(If yes, attach copy of "driver's report of accident")

Clearly Describe What Happened: _____

_____

_____

_____

_____

WITNESSES AND OTHER INJURED, ILL OR INVOLVED:

Name: _____ **Phone #:** _____ **Name:** _____ **Phone #:** _____

Name: _____ **Phone #:** _____ **Name:** _____ **Phone #:** _____

SEE REVERSE SIDE OF FORM FOR SECTION IV.

SECTION IV. SUPERVISOR/MANAGER ACCIDENT ANALYSIS

DID INJURED EMPLOYEE RECEIVE PRIOR TRAINING IN TASK? ☐ YES ☐ NO

CONTRIBUTING CAUSES OF ACCIDENT: _____

RECOMMENDATIONS FOR PREVENTION OF RECURRENCE:

Supervisor: _____ **Date:** _____

Employee: _____ **Date:** _____