EMPLOYEE’S REPORT OF INJURY

Please Print

Employee’s Name __________________________________ Date _________________
(Last, First, Middle)

Address __________________________City _____________State_______Zip_________

Home Phone Number _____________________ Social Security # ___________________

Date of Birth__________________Sex______Date of Hire__________________________

Occupation____________________________________Work Number________________

Cell or pager#_______________________Marital Status__________#Dependents______

Date of accident_____Time began work______Time of Occurrence ____am☐ pm ☐

Injury☐ Exposure☐ Illness☐ Any loss days – No ☐ Yes☐

Dates Days Missed____

Location where accident occurred____

City_________________________State_______

Date / Time Accident Reported____________________To Whom?___________________

Name(s) of Witness(es)____

Describe in detail what happened and what part of the body was injured:_____________

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Employee's Report of Injury Continued:

Date and time you first sought medical attention________________________________

Name of Doctor and/or Hospital____

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What could have been done to prevent this accident?____________________________

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Signature of Employee______________________________Date__________________