EMPLOYEE'S WORK INJURY REPORT

Personal

Name _____ Social Security Number _____

Address _____ Birth Date _____ Sex M ☐ F ☐

City, State _____ Zip _____ Telephone (___) ___ - _____

Married ☐ Single ☐ Number of Dependents _____

Employment

Job Title _____ Employment Date _____

Salary/Hourly Rate _____ Hours Worked Per Day _____

Building Location _____ Time Work Day Begins _____

Injury/Illness

Date of Injury _____ Time of Accident? _____

Where did this injury occur? _____

What were you doing when injured? _____

_____

How did the injury occur? _____

Describe the injury or illness in detail and indicate the part of the body affected. (Designate right or left if appropriate.) _____

_____

Any previous similar injury? If yes, explain _____

Was this injury witnessed? If so, by whom? _____

Treatment

Designated Medical Treatment Center _____

Diagnosis/Care Prescribed _____

Family Physician _____ Telephone Number _____

Did you lose time from work? Yes ☐ No ☐ How long? _____

Have you returned? _____ If yes, what was the date? _____

Contact

You must contact Pam at the Central Office, 285-3102, upon your return to work.

Return completed form within 24 hours of the accident to Pam at the Central Office or Fax 285-6075.

_____ _____

Employee Signature Date

Approved: January 22, 2001
Reviewed: May 11, 2015
Revised: