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| --- | --- |
| **Employee Report of Injury****[ ]  For Records Only** |  |

|  |
| --- |
| personal Information |
| Last Name |  | First | M.I. | Today’s Date |  |
| Street Address |  | Apartment/Unit # |  |
| City |  | State | ZIP |  |
| Phone |  | E-mail Address |  |
| Injury Date:  |  | Time of Injury: A.M. / P.M. | Social Security # |  |
| Gender:  |

|  |  |  |  |
| --- | --- | --- | --- |
| Male [ ]  | Female [ ]  | DOB: | Marital Status: [ ]  Married [ ]  Single |
|  |  |

 |
| Date of Hire: | Position: |
|

|  |  |
| --- | --- |
| Employment Status: Part-time [ ]  Full-time [ ]  Temporary [ ]  Seasonal [ ]    |  |

 |
| **INCIDENT DETAILS**   |
| Were you injured? |

|  |  |
| --- | --- |
|  YES [ ]  |  NO [ ]  |

 | If yes, part of body injured: |  |
| Did the incident occur on premise: |  YES [ ]  |  NO [ ]  | Location of Accident: |
| Materials Used:  |  YES [ ]  |  NO [ ]  | List Materials Used:  |
| Were there any witness: |

|  |  |
| --- | --- |
|  YES [ ]  |  NO [ ]  |

 | If yes, please provide name and phone number below: |  |
| **Witness: (Please provide name and phone number)** |
| Witness #1 - Name Phone Number |
| Witness #2 – Name Phone Number |
| **In our own words, please describe how the accident occurred: (**For additional comments please complete on back of this form) |
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**Please selected the option below of choice to seek treatment:**

|  |  |
| --- | --- |
| YES [ ]  | Yes, I have elected to seek treatment as a result of this accident. |
| No [ ]  | No, I elected **NOT** to seek treatment as a result of this accident |
| Physician/Hospital Information: |  |
| Disclaimer and Signature |
| I certify that my answers are true and complete to the best of my knowledge.  |
| **Employee Signature:** |  | **Date:** |  |
| **Manager Signature:** |  | **Date:** |  |

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| **Additional Comments:** |
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