

REPORT OF WORK-RELATED INJURY OR ILLNESS

TO BE COMPLETED BY EMPLOYEE OR SUPERVISOR FOR ALL WORK-RELATED ACCIDENTS OR ILLNESSES.
MUST BE SUBMITTED TO PERSONNEL WITHIN 24 HOURS OF INCIDENT OR KNOWLEDGE OF INCIDENT.

EMPLOYEE NAME: _____ SOCIAL SECURITY #: _____ - _____ - _____
DEPARTMENT: _____ JOB CLASS: _____
WORK PHONE: _____ HOME PHONE: (_____) _____ MARITAL STATUS: ___ Single ___ Married
NUMBER OF DEPENDENT CHILDREN: _____ LIST ANY OTHER DEPENDENTS: _____
DATE OF BIRTH: _____ DATE OF HIRE: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ A.M. / P.M.
LOCATION WHERE INJURY OCCURRED: _____
NATURE OF ILLNESS/INJURY (Be specific, for example: surface cut, multiple fracture, etc.): _____
INJURED PART OF BODY (Be specific, for example: right, lower arm; middle finger on left hand, etc.): _____
DESCRIBE HOW INJURY/ILLNESS OCCURRED (Be specific, for example: struck by..., slipped on stairs and fell..., etc.): _____
WHO WITNESSED THIS INJURY/ILLNESS? _____
TO WHOM WAS INJURY/ILLNESS REPORTED? _____

LIST ANY PHYSICIANS OR HOSPITALS WHO HAVE TREATED THIS INJURY/ILLNESS (use reverse if more space is needed):
Doctor/Hospital: (1) _____ (2) _____
Address: _____
Dates of Treatment: _____

HAS ANY WORK TIME BEEN LOST DUE TO THIS INJURY/ILLNESS? _____ yes _____ no DATES: _____
LIST TIMES OF ANY ABSENCES OF LESS THAN ONE DAY: _____
HAS EMPLOYEE RETURNED TO WORK? _____ yes _____ no DATE EMPLOYEE RETURNED TO WORK: _____
HOW MANY DAYS IS EMPLOYEE EXPECTED TO BE INCAPACITATED: _____

COMMENTS: _____

EMPLOYEE'S SIGNATURE: _____ Date: _____

SUPERVISOR'S SIGNATURE: _____ Date: _____

WORKERS' COMP AGENT: _____ Date: _____

