

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: _____

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