EMPLOYEE'S REPORT OF INJURY/INCIDENT

Employee's name:_____ Male _____ Female_____

Home address: _____

Phone # (_____) _____ Date of birth:_____ SSN:_____-_____-_____

Specific location of accident:_____

Date of Incident: ____/____/____ Time of Incident: ____:____ a.m./p.m. (Circle)

Job or function being performed at time of incident: _____

Describe how incident occurred: (include events that occurred immediately before the accident, condition of surroundings, etc.):

_____

_____

_____

_____

_____

_____

_____

Name of supervisor:_____ Date/time reported to supervisor:_____

Was medical treatment given away from worksite? Yes___ No ____

If yes, Name & Address of physician/health care professional:_____

_____ Phone:(___)_____

IF INJURED, CHECK ALL APPROPRIATE BOXES:

TYPE OF INJURY	BODY PART INJURED		DISPOSITION
____ laceration	____left	____ right	____treated in ER
____ abrasion	____upper	____ lower	____treated by Doctor
____ puncture	____head/eye	____ neck	____treated on Site
____ burn	____chest	____abdomen	____ _____
____ fracture	____arm	____ shoulder	
____ strain/sprain	____foot/toe	____leg/ankle	
____contusion/bruises	____knee	____hand/finger	
____bite	____ _____		
____rash			
____loss of consciousness			
____ _____			

Signature of employee:_____ Date: _____/_____/_____