

Work-Related Injury Report Form

This form should be completed and submitted to the Human Resources office as soon as possible after an injury. The injured employee should complete this report form, or the supervisor, if the employee is unable.

CLAIM #: _____

PERSONAL INFORMATION

Print Employee Name (Last, First, MI):		Today's Date
Home address (street, city, zip)		Birth date
Home phone number	Work phone number	Hire date
Job Title		Rate of Pay
Social Security#	Supervisor's name & phone extension	
<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	Hours per day _____ / days per week _____
		<input type="checkbox"/> male <input type="checkbox"/> female

INJURY / ACCIDENT INFORMATION

Date of Injury	Time of injury	Has employee returned to work?
Did injury cause loss of time from work? (dates, amount of time)		Provide names of any witnesses to the accident/injury:

Describe injury: What parts of the body were affected? What type of injury?

Describe what the employee was doing and how the injury occurred:

Describe any First Aid given at the scene of the accident/ injury: _____

Was injured treated in an emergency room? yes no Taken by ambulance? yes no

Name of treating doctor _____

Name medical provider(s): _____

Address (street, city, state, zip) _____

phone number _____

Treatment received _____

Employee signature: _____ Date _____

OR Supervisor signature: _____ Date _____