EMPLOYEES WORK RELATED INJURY REPORT
Must be reported to Personnel/Risk Management Department within 24 hours

Name _____ Social Security # _____

Address _____ Telephone # _____

Name and telephone # of friend or relative _____

_____

Date of Birth _____ Sex _____

Marital Status _____ Number of minor children _____

Department _____ Date hired _____

Date of Accident_____

Describe fully how accident occurred, and state what employee was doing when injured. _____

_____

_____

Names and address of witnesses _____

_____

Describe the injury or illness in detail and indicate the part of body affected _____

_____

Has injured returned to work? _____

Name and address of physician (if known) _____

Name and address of hospital (if known) _____

Date _____ Employees Signature _____

Supervisors Report of Accident

Name of injured _____ Speak English _____ Yes ____ No

Occupation when injured _____

Was this his/her regular occupation? _____

Machine, tool or thing causing injury _____

Location where accident occurred – Street # and City _____

_____

Did accident occur on employers premises? _____ Yes _____ No

Department where injured _____

Department regularly employed in _____

Date of Injury _____ Day of week _____

Hour of day _____ A.M. _____ P.M.

When did you or foreman first know of injury? _____

Date _____ Supervisor Signature _____