Employee's Injury Report

This form must be completed in detail and signed by the injured employee.

EMPLOYEE INFORMATION								
Your Full Name								
Employer			Location of Accident					
Social Security Number (Last 4 Digits) XXXX-XX-	Date of I	Birth	Department You Work For					
Your Address (Street, City, State, County,	Zip)			Su	pervisor's Name			
Phone Number Where You Can Be Reached			Job Title at Time of Injury					
Date of Hire		How Long in Current Position? YrsMonths		Months				
DETAILS OF THE INJURY								
Date of Injury		Time of Injury	AM / PI	М	Date You First Lost Time			
Where in the workplace did your injury occ	our?							
Describe in detail how your injury occurre	d.							
What safety equipment were you using at the time of the accident?								
what surery equipment were you using at the time of the accident?								
What can be done to prevent this type of injury in the future?								

When were you first aware of this injury?						
When did you first notify your supervisor of your injur	γ?					
What part of your body is injured?	Describe the injury.					
On the diagram below, please circle the part(s) of your body where you are experiencing pain due to this injury. R						
In the incident that caused your injury, was there damage to any property or equipment? Describe any damage.						
 ✓ I certify that the information contained in this report is true and correct. ✓ I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes. ✓ I hereby authorize the release of all medical records relating to the above noted incident to my employer, his agent or insurance company. 						
Employee's Printed Name	Employee's Signature	Date				
✓ I certify that the above employee signed and dated this form in my p		he/she understood all quest	ions and			
Witness Printed Name	Witness Signature	Date				
Supervisor's Printed Name	Supervisor's Signature	Date				