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# REPORT OF WORK INJURY

## SECTION I. EMPLOYER INFORMATION AND IDENTIFICATION

**CLIENT NAME:** **TELEPHONE NUMBER:**

**ADDRESS:** **CITY, STATE & ZIP:**

## SECTION II. EMPLOYEE INFORMATION

**Did Employee: Stay on Job ☐ Go Home ☐ See Physician ☐ Go to Hospital ☐ Other ☐ Return to Work ☐**

**First Name:** **Initial:** **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: Full Time ☐ Part Time ☐ Other (describe) ☐**

**Length of Employment (Days/Mo/Yrs):** **Time in Occupation at Time of Injury( Days/Mo/Yrs):**

## SECTION III. ACCIDENT DESCRIPTION

**LOCATION OF ACCIDENT:** **DATE & TIME OF INJURY/ILLNESS:**

**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 ☐**

**Clearly Describe What Happened:**

**WITNESSES AND OTHER INJURED, ILL OR INVOLVED:**

**Name:** **Phone #:** **Name:** **Phone #:** **Name:** **Phone #:**

## 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:**