EMPLOYEE WORK-RELATED INCIDENT/INJURY/OCCUPATIONAL DISEASE REPORT

Employer Name: _____

Employee Information:

First Name: _____ **Last Name:** _____ **Date:** _____

Home Address: _____ **City:** _____ **Zip:** _____

Personal Phone: _____ **Work Phone:** _____

Soc Sec#: _____ **Sex:** ☐ **Male** ☐ **Female** **DOB:** _____ **Age:** _____

Date of Hire: _____ **Occupation:** _____ ☐ **Full Time** ☐ **Part Time**

# of days in work week: _____ **Normal hours of employment: Start** ___ : ___ ☐**am** ☐**pm** **End** ___ : ___ ☐**am** ☐**pm**

Incident Information:

Date of Incident: _____ **Time of Incident:** ___ : ___ ☐**am** ☐**pm**

Building name and address of location where incident occurred, Name: _____

Address: _____ **City:** _____ **Zip:** _____

Specific location (ex. First floor hallway, Classroom 201, Steps main entrance): _____

Detailed description of how incident occurred: _____

_____

_____

_____

Were you injured or become ill: ☐ **Yes** ☐ **No** **If yes, did you require medical treatment:** ☐ **Yes** ☐ **No**

If yes, list names and addresses of all medical facilities and providers (visited or plan to visit): _____

_____

Did you lose any time from work: ☐ **Yes** ☐ **No** ☐ **Unknown at this time** **If yes, list dates:** _____

Did you notify a Supervisor: ☐ **Yes** ☐ **No**

If yes, Name of Supervisor: _____ **Date:** _____ **Time:** ___ : ___ ☐**am** ☐**pm**

Detailed description and nature of injury or illness (Right wrist, Left thumb, Lower back etc.): _____

_____

_____

List all Witnesses: _____

I, _____ *herein certify that the information above is true and to the best of my knowledge.*
(Print employee/your name above)

Employee Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____ Business Official: _____ Date: _____