

Employee's Report of Injury

(to be completed by employee only)

Employee's Name Male Female Date
Last First Middle

Date of Birth Home Telephone Number

Home Address City State Zip Code

Job Title Length of Employment

Location of Accident
Address/Building/Room # Area: (loading dock, rest room, classroom, etc.)

Date of Accident Time of Accident AM. PM.

Describe fully how accident occurred: (including events that occurred immediately after the accident)

Details:

Describe bodily injury sustained: (be specific about body part(s) affected)

Details:

Recommendation on how to prevent this accident from recurring:

Details:

Name of Supervisor Phone Number

Name of Witness(es) Phone Number(s)

When did you report the accident to your supervisor?

If not your supervisor, to whom did you report the accident/injury to?

Do you require medical attention? Yes No Maybe

Name of your treating physician Date

Signature of Employee Date