EMPLOYEE REPORT WORK RELATED INJURY/ILLNESS

Employee:_____

Dept: _____ **Supervisor:** _____

Work Schedule (circle): SUN MON TUES WED THURS FRI SAT

Shirt Start Time: _____**Shift End Time:** _____ **Full Time?: Y/N**

Date of Hire: _____ **Date of Birth:** _____ **SSN:** _____

Employee Mailing Address: _____

Phone Number: _____

Date of accident:_____ **Time of Accident:** _____ **Location:** _____

Nature of injury:_____

Part of Body: _____
(Please be specific)

Explain what the employee was the employee was doing when injured:

_____

_____

Note any substance/object that directly injured employee:_____

_____

Name of any witnesses to the incident:_____

Medical care provided at scene: __yes __no

Description of medical care provided at scene: _____

_____

Date employee stopped work: _____ **Date returned to work:**_____

Employee sought outside medical treatment: __yes __no

Name of Doctor: _____ **Phone Number:**_____
Name of Hospital: _____ **Phone Number:**_____

Injuries must be reported immediately. Injuries reported after five days may not be approved by the Workers Compensation Board as valid claims. ***Return completed forms to the Office of Employee Engagement , Room 126 Duns Scotus***

Employee Signature: _____