



REPORT OF WORK INJURY			
<b>SECTION I. EMPLOYER INFORMATION AND IDENTIFICATION</b>			
CLIENT NAME:		TELEPHONE NUMBER:	
ADDRESS:		CITY, STATE & ZIP:	
<b>SECTION II. EMPLOYEE INFORMATION</b>			
Did Employee: Stay on Job <input type="checkbox"/> Go Home <input type="checkbox"/> See Physician <input type="checkbox"/> Go to Hospital <input type="checkbox"/> Other <input type="checkbox"/> Return to Work <input type="checkbox"/>			
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 <input type="checkbox"/> Part Time <input type="checkbox"/> Other (describe) <input type="checkbox"/>			
Length of Employment (Days/Mo/Yrs):		Time in Occupation at Time of Injury( Days/Mo/Yrs):	
<b>SECTION III. ACCIDENT DESCRIPTION</b>			
LOCATION OF ACCIDENT:		DATE & TIME OF INJURY/ILLNESS:	
Was an employee injured in the accident? Yes <input type="checkbox"/> No <input type="checkbox"/>		Did the incident involve employee illness? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Did the incident involve property damage? Yes <input type="checkbox"/> No <input type="checkbox"/>		Was a motor vehicle involved? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Clearly Describe What Happened:			
WITNESSES AND OTHER INJURED, ILL OR INVOLVED:			
Name:	Phone #:	Name:	Phone #:
Name:	Phone #:	Name:	Phone #:
<b>SECTION IV. SUPERVISOR/MANAGER ACCIDENT ANALYSIS</b>			
DID INJURED EMPLOYEE RECEIVE PRIOR TRAINING IN TASK? Yes <input type="checkbox"/> No <input type="checkbox"/>			
CONTRIBUTING CAUSES OF ACCIDENT:			
RECOMMENDATIONS FOR PREVENTION OF RECURRENCE:			
Supervisor:	Date:	Employee:	Date: