

# Employee's Report of Injury

(to be completed by the employee only.)

Employee's Name: \_\_\_\_\_ Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_

\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: \_\_\_\_\_

Social Security/ID Number: \_\_\_\_/\_\_\_\_/\_\_\_\_ Hourly Wage: \$ \_\_\_\_\_

Job Title: \_\_\_\_\_ Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_

Part-Time / Full Time \_\_\_\_\_ Time Normally Worked: \_\_\_\_:\_\_\_\_ to \_\_\_\_:\_\_\_\_ Time of Accident: \_\_\_\_:\_\_\_\_  
circle one

Location of Accident: \_\_\_\_\_  
Address Area (loading dock, desk, etc.)

Describe fully how accident occurred (including events that occurred immediately before the accident):  
\_\_\_\_\_  
\_\_\_\_\_

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

Name of Supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_

Name(s) of Witness(es): \_\_\_\_\_  
attach all witness statement(s) to this form

Date HR Notified: \_\_\_\_/\_\_\_\_/\_\_\_\_ Treatment Received:  None

Name of Treating Physician: \_\_\_\_\_  First Aid

Treatment Location: \_\_\_\_\_  Clinic/Hospital

Signature of Employee: \_\_\_\_\_  ER

Date: \_\_\_\_\_  Hospital Overnight

Hospital > 24 hours