

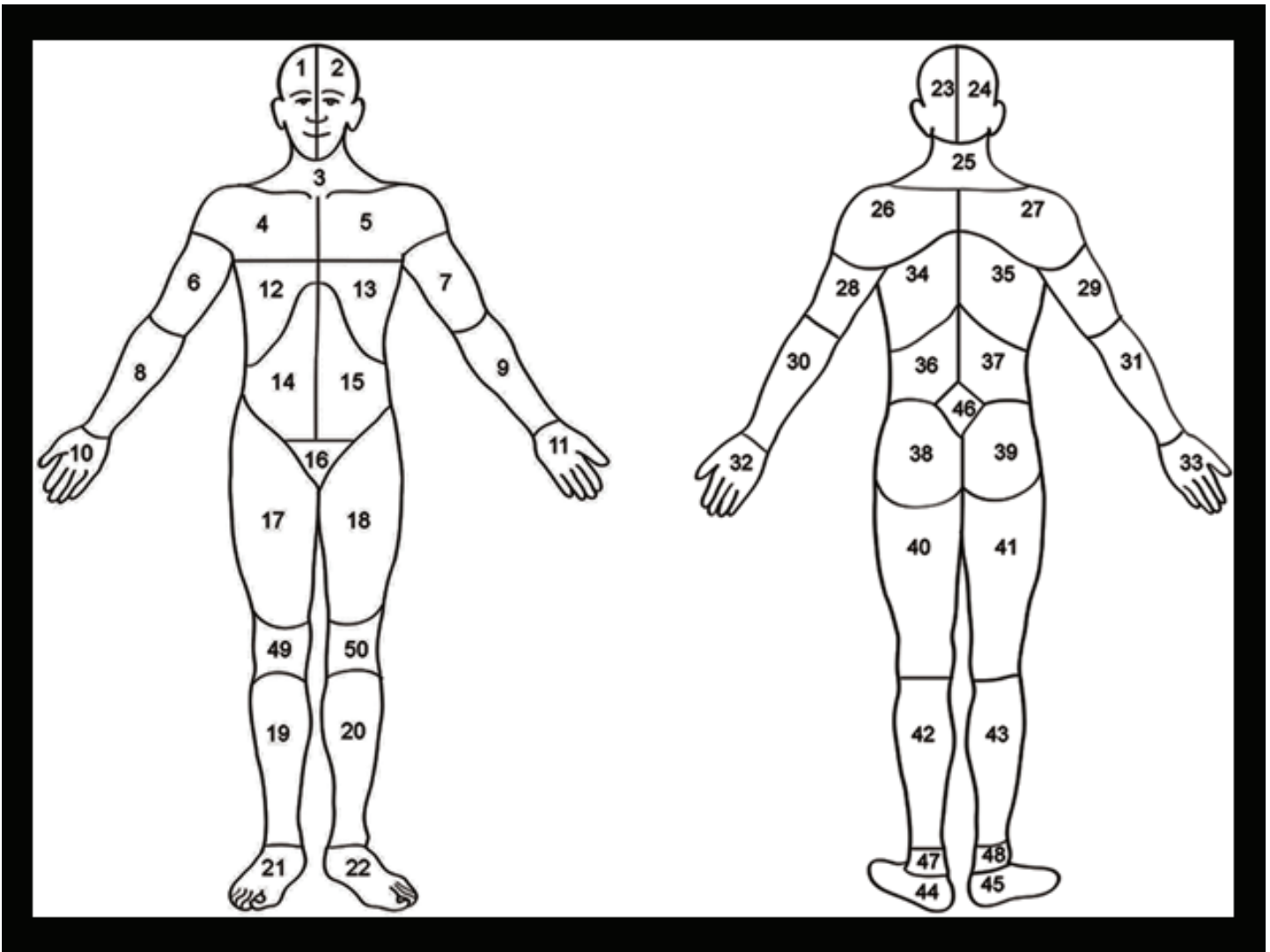


# Work-Related Injury and Illness Employee Report

EMPLOYEE INFORMATION	Employee Name:	Social Security Number:	Phone (Work):
	Date of Birth:	Sex:	Marital Status:
	# of Dependents Under 18:	Date of Hire:	
	Address (Home):		Phone (Home):
	Job Title:	Work Hours (Schedule):	
	Department:	Supervisor Name:	Supervisor Phone (Work):
	Do you have other employment? YES/NO	If Yes, where?	

INCIDENT	Date of Incident:	Time:	AM/PM	Time Work Start:	Time Work End:
	Location of incident (Job location, building name, room number, etc.):				
	Description: How did the incident occur? What was the activity and any tools, equipment, or materials you were using? (Example: I was opening a box of paper using a razor blade. The razor blade slipped on the surface of the box, and I cut my right index finger.)				
	List the body part(s) injured and type of injury. (Example: Right index finger skin cut)				
	Did you report the incident? YES/NO	If Yes, to whom?			Date Reported:
	Were there witnesses? YES/NO	If Yes, was witness statement form completed? YES/NO			
	Is this a new injury? YES/NO	If No, what is the date of original injury:			

Mark in the diagram below the body part(s) injured and list the type of injury next to injured part.



<b>TREATMENT</b>	Did you receive first aid? YES/NO (If No, skip this section)	Do you need medical treatment? Yes/ No (If No, why not?)
	If Yes, list medical provider name and address:	

**By signing this form, the employee certifies that the information provided is true and correct to the best of the employee's knowledge.**

Employee Signature:	Date:
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