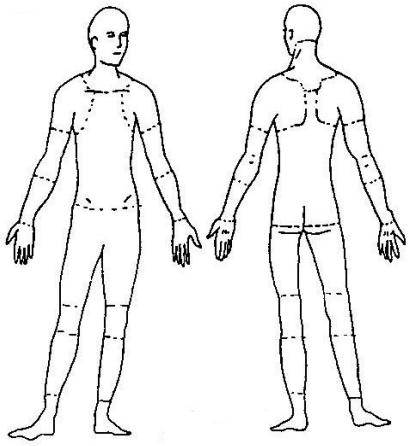
Employee's Report of Injury Form

Instructions: Employees shall use this form to report for all workers compensation claims. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by employees as soon as possible and submitted.

Person Injured			
Last Name	First Name	Middle Initial	
Social Security Number	Phone Number		
Address	City	State	Zip Code
Check Box □ Male □ Female	Date of Birth		
Occupation when injured	Was this your regular occupation □ Yes □ No		
Length of time employed	Hours worked per day	Days worked per week	

Job title:	
Supervisor:	
Have you told your supervisor about this injury? ❑ Yes ❑ No	
Date of injury:	Time of injury:
What were you doing at the time and how did the injury occur?	
Where, exactly, did it happen?	
What parts of your body were injured? 	

What type of shoes were you wearing at the time of the injury?
Did you lose time from work? ❑ Yes ❑ No If so, when did the time out of work start? When did the time out of work end?
Names of witnesses (if any):
Did you see a doctor about this injury/illness? ❑ Yes ❑ No If yes, whom did you see? _____ Doctor's phone number: _____ Date & time of doctor's appointment: _____
Has this part of your body been injured before? ❑ Yes ❑ No If yes, when? _____ Name of Treating Physician: _____ Did you have any of the following treatments? ❑ MRI ❑ Surgery ❑ Diagnostic Testing ❑ Other If "Other", describe in detail: _____ _____ Did the Physician write any prescription(s) due to this injury? ❑ Yes ❑ No If so, please list medications:_____
List any current medical problems/conditions: _____ Where you taking any medications prior to the accident? ❑Yes❑ No
Any Prior Insurance Workers Compensation Claims? ❑Yes❑ No If so, when? _____ Is so, who was the treating physician? _____ What body part(s)? _____

Your signature:	***Date:***