Employee Report of Injury

(To be filled out with Supervisor within 24 hours of accident/injury)

Employee Name:_____ **D.O.B.:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone Number:_____ **Social Security:**_____

Occupation:_____ **Work Schedule:**_____
(Hours from when to when: 7:30am – 4:30pm)

Work Site:_____

Site of Accident/Injury: _____

Date of Accident:_____**Time of Accident:**_____**am/pm**

Describe <u>what</u> you were doing when injured *(specify any tools, equipment being used, etc.)***:**

_____

_____

Describe <u>where</u> the accident happened *(sidewalk, classroom, gym, etc.)***:** _____

_____

_____

Describe <u>how</u> the accident occurred *(be specific)***:** _____

_____

_____

Describe injury *(cut on right hand, sprained left ankle, etc.*)**:** _____

Witnesses or other persons involved: _____

How might the injury been prevented? _____

_____

Date of this Report:_____

Employee's Signature:_____