Employee Injury Report

Date of this report: ______________________ Person Reporting: ______________________

Name of Injured Person: ______________________ Position: ______________________

Type of Accident: Personal Injury Motor Vehicle Property Damage Equipment Damage

Date of Injury: ______________ Time: __________ ☐ a.m. ☐ p.m.

First Aid Case: Disabling (lost-time) injury: 1st day of time loss ______________

Description of Incident - Answer for All Cases

1. Please describe exactly what happened: ______________________

2. Did the injured commit an unsafe act? ☐ Yes ☐ No Describe: ______________________

3. Was another person involved? ☐ Yes ☐ No What did that person do which contributed to the incident?

4. Did defective equipment, furnishings or other unsafe conditions contribute to the incident? ☐ Yes ☐ No
What was wrong? ______________________

5. What persons other than the injured saw the incident? ☐ Yes ☐ No Identify witness (s): ________________

NATURE OF INJURY		PART OF BODY INJURED		
☐ Fracture	☐ Burn or scald	☐ Neck	☐ Abdomen	☐ Hip
☐ Dislocation	☐ Superficial injury	☐ Head	☐ Back-Spine	☐ Thigh
☐ Sprain or Strain	☐ Internal injury	☐ Eye	☐ Pelvis	☐ Knee
☐ Laceration or avulsion	☐ Foreign body retained	☐ Nose	☐ Shoulder	☐ Lower Leg
☐ Contusion	☐ Effect of electricity	☐ Mouth/Jaw	☐ Upper arm	☐ Ankle
☐ Perforation or puncture	☐ No apparent injury	☐ Chest	☐ Elbow/Forearm	☐ Toe
☐ Broken tooth or teeth	☐ Other ________________	☐ Wrist/Hand	☐ Finger	☐ Other

Was emergency treatment given? ☐ Yes ☐ No By Whom? ______________________

Describe any other treatment given: ______________________

Date injured person examined: ____________ Hour: ______________ ☐a.m. ☐ p.m.

Corrective Action Taken (if needed)

What steps have been taken to prevent similar occurrences and what further recommendations are made? (Replace or repair equipment; instruct employee, or other action?) ______________________

Name and Signature of Reporting Supervisor

<u>Please use back of this form for additional details.</u>

Reviewed by Ken/Will (date & initial):____________ Reported to insurance company YES NO

Listed on the OSHA Log YES NO Pictures taken YES NO

Witness Report

Date of Incident: ______________________________ **Time**: ________________________

Location of Incident: ____

Witness Information: ____

Last Name First Name MI

☐ Employee ☐ Vendor/Contractor ☐ Visitor/Guest

Employee # (if applicable): ________________

Street Address: ____

Apt. / Unit No.: ________________________________

City ______________________________ State ________ Zip __________

Telephone:______________________ Work/Cell Phone: ______________________

Please use reverse side if you need more space

1. **Describe incident in your own words:**____

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2. **Describe/Identify anyone else or anything involved:**_____________________________

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3. **Any other comments:**____

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Completed by:

____

Print Name Signature Date

Please return this form to Ken/Will within 4 hours of incident.

Reviewed by Ken/Will (date & initial):__________