



Employee's Report of Injury/Occupational Illness

(Please complete this form and give original to your supervisor within 24 hours of the incident.)

PLEASE PRINT LEGIBLY

Employee's Name: _____
Last First Middle Sex: _____

Date of Birth: ____/____/____ Home Phone # () _____ Work Phone # () _____

Home Address: _____

City, State, Zip Code: _____

Present job title: _____ Department: _____ Date of Hire: _____

Marital Status: _____ Number of Dependents: _____

Social Security No.: _____ Salary: \$ _____ Bi-weekly/hourly

Date and Time of Injury/Illness: _____ Time Workday Began: _____

Location where incident occurred: _____
Building Area (hallway, etc.)

Describe fully how injury/illness occurred: _____

(continue on other side, if necessary)

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

(continue on other side, if necessary)

Name(s) of Witness(es): _____

Recommendation on how to prevent this injury/illness from recurring: _____

Name of Supervisor: _____
Last First Middle

Date & time reported the injury/illness to your supervisor _____

Signature of Employee: _____ Date: _____