**Employee Report of Incident**

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| **Instructions** | |
| **Complete this form legibly and accurately. If you have any questions, contact your supervisor, injury coordinator, or general manager.**  ***Please note:* This form must be completed within 24 hours of the incident.** | |
| **Employee:** | Complete the entire form when any injury requires medical attention.  Submit the form to your supervisor/general manager. |
| **Supervisor/General Manager:** | **Call** the insurance adjuster at ***Phone Number***.  **Fax** the completed and signed form to:   1. Insurance Adjuster ***Name Fax Number*** 2. Injury Coordinator ***Name Fax Number*** 3. Division Vice President ***Name Fax Number*** |

I have read and understand the instructions on this form. I understand that if I have questions regarding this form, I shall contact my supervisor.

Employee Name Employee Signature Date

Supervisor/Manager Name Supervisor/Manager Signature Date

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| **Section 1** | | | | | |
| **Name (First, MI, Last):** | **Birth Date:** | **Home Phone:** | | **Location Code:** | |
| **Home Address:** | **Job Title:** | | **SSN:** | | |
| **Initial Complaint:** | | | **Date:** | | |
| **Section 2** | | | | | |
| **Where did the injury occur?**  🞎 **On site** 🞎 **Off site (provide address):** | | | **Shift:**   * **1** * **2** * **3** | | **Date:** |
| **Do you have a job at another company?** 🞎 Yes 🞎 No | | | | | |
| **Are you:** 🞎 Right handed 🞎 Left handed 🞎 Ambidextrous (use both hands) | | | | | |
| **Side of body with the most pain:** 🞎 Left 🞎 Right 🞎 Both | | | | | |
| **Specific body part in pain:**  🞎 Head 🞎 Eye 🞎 Back 🞎 Arm 🞎 Shoulder 🞎 Hand  🞎 Fingers 🞎 Wrist 🞎 Leg 🞎Knee 🞎 Foot  🞎 Other: | | | | | |
| **Shoulder, elbow, or wrist complaints:** | | | | | |
| **What job do you perform that is the most difficult?** | | | | | |
| **Briefly describe the activities that you perform relating to the incident.** | | | | | |
| **How long has this task been assigned to your job?** | | | | | |
| **Where you using the required safety equipment?** 🞎 Yes 🞎 No | | | | | |
| **What job/activity were you doing when injured?** | | | | | |
| **What specific equipment were you working on (include model number)?** | | | | | |
| **Describe the events that contributed to the incident.** | | | | | |
| **What type of preparations did you make to perform the assigned task? What steps have to be completed to accomplish the task?** | | | | | |
| **Which task were you doing just prior to the incident?** | | | | | |
| **What task contributed to the incident?** | | | | | |
| **Witness name(s) and phone numbers:**  **Name Phone Number** | | | | | |
| **Recommendations for prevention of similar occurrences:** | | | | | |
| **List names and dates of medical care, if already sought.**  **Physician Name Date of Treatment Phone Number** | | | | | |

**What part of the employee’s body was injured? Please circle.**

**Back**

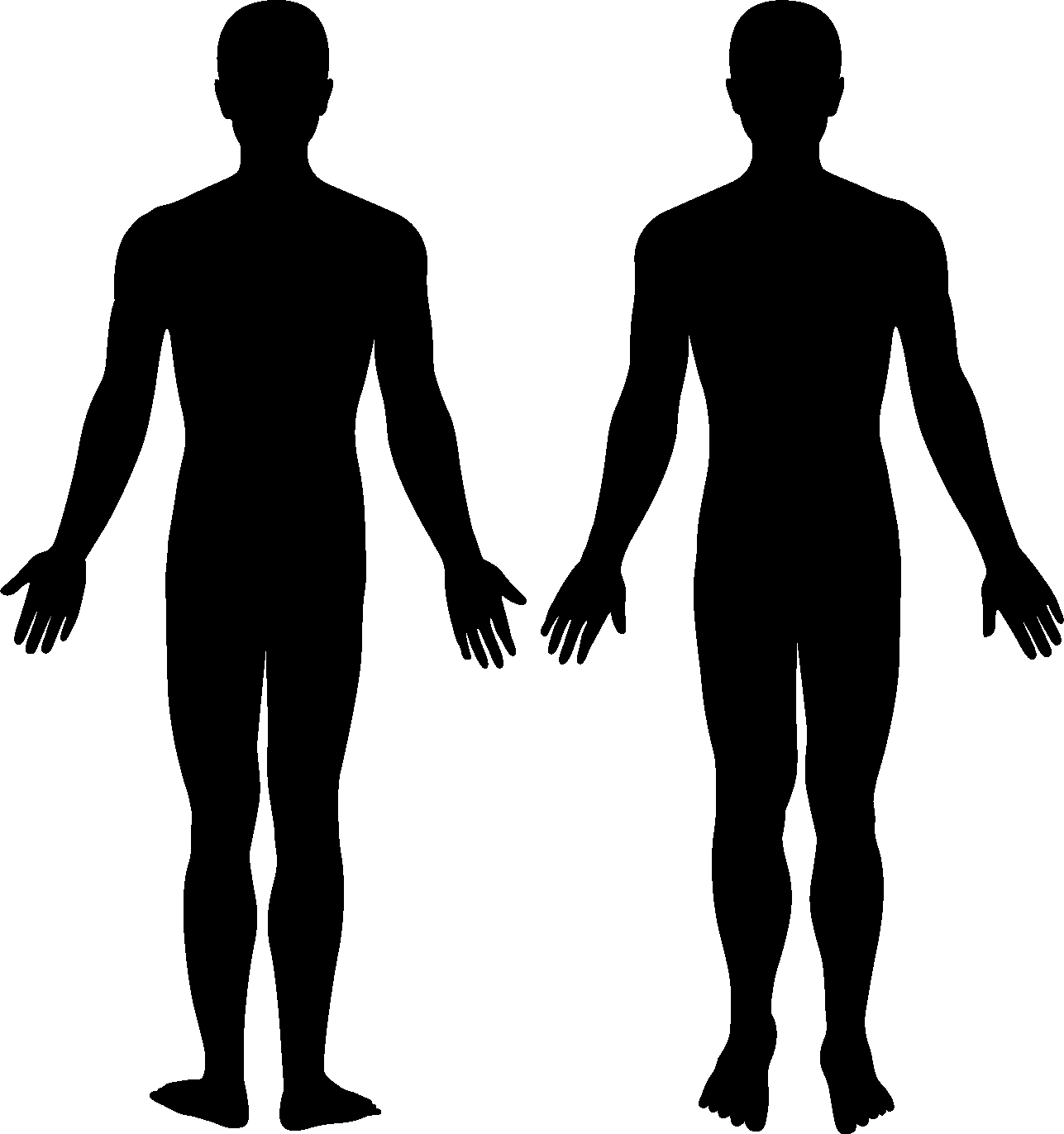
**Front**

**Left**

**Right**

**Left**

**Right**



**Certificate of Accuracy and Authorization**

**to Release Relevant Records**

I hereby certify that the information reported on this report is correct to the best of my knowledge and belief. I realize that anyone who obtains workers’ compensation by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation to which he/she is not entitled, is subject to felony prosecution for fraud and/or termination of employment.

I hereby authorize any and all records to my employer. Specific type of information to be disclosed: employment records and medical records of treatment for physical and/or emotional illness, to include psychological testing, workshop reports, education records, and treatment of records of alcohol or drug abuse, limited to records dealing with the parts of the body that were allegedly injured in the above incident. This consent may be revoked at any time; revocation must be made in writing. It shall be valid no longer than is reasonable necessary to accomplish the purpose for which it was given. A copy of this form will serve as the original.

Employee Name Employee Signature Date