INCIDENT/INJURY REPORT

Branch/Client _____ Date _____

Associate Name _____ Date of Hire _____

Incident Location (*in facility*) _____

First Aid Administered by _____ ☐ *First Aid Refused*

What Treatment was Administered? _____

Employee was referred for further immediate treatment ☐ *Yes* ☐ *No*

Health Care Facility/Hospital _____ Date _____

SECTION TO BE COMPLETED BY THE EMPLOYEE

Can you read and understand English? ☐ *Yes* ☐ *No* Do you need help with this report? ☐ *Yes* ☐ *No*

Name *(Last, First, Middle Initial)* _____ Date of Birth _____

Address _____ Address 2 _____

City _____ State _____ Zip _____

Social Security # _____ Home Phone # _____

Date of Injury _____ Time of Injury _____ ☐ *Incident Happened During Overtime Hours*

Date you reported this injury _____ Who did you report it to? _____

Shift/Crew _____ Department _____ Supervisor _____

Your Job Title _____

What were you doing when the Incident happened? How did it happen? _____

_____

Describe your injury (*example: sprained left ankle, cut right forearm, burn left ring finger, etc.*) _____

_____

Did you injure any other part of your body? ☐ *Yes* ☐ *No* Which part(s)? _____

Who are the witnesses to your incident? _____

If "no witnesses", where were you? _____

What safety/ppe equipment were you wearing? (*be specific*): _____

I authorize release of medical records to my employer & to the workers' compensation insurance carrier for treatment of this injury or illness. I declare that all the facts above are true and i understand that worker's compensation insurance fraud is a criminal offense, punishable by law:

_____ _____

Employee Signature Date