



EMPLOYEE'S REPORT OF WORK-RELATED INJURY OR ILLNESS

A. EMPLOYEE INFORMATION						
Injured Employee's Name		Department		Job Title		
Date of injury	Time of injury a.m./p.m.	Date injury was reported	Time reported a.m./p.m.			
Who did you report the injury/illness to:						
Time you reported for work on day of injury:			Did you leave work as a result of injury/illness? (Circle Answer) Yes/No If yes, time left:			
Have you returned to work? (Circle Answer) Yes/No If yes, date/time returned:			Have you sought medical attention? If yes, where?			
Normal work schedule at time of injury (complete for whole week)						
MON	TUE	WED	THU	FRI	SAT	SUN
B. DESCRIPTION OF ACCIDENT/ILLNESS						
Where did accident occur?						
Describe how accident occurred? What were you doing?						
What equipment/materials were being used at time of injury?						
Describe the nature of the injury. Indicate what part of the body was hurt and specify right or left as applicable.						
Names and phone numbers of witnesses:						
C. SIGNATURE						
Employee's Signature					Date	

Human Resources Office Use Only					
Date Rec'd	EE Hourly Rate	Weekly Reg Hrs	Weekly OT Hrs	Dr. Report Rec'd	Date Claim Filed