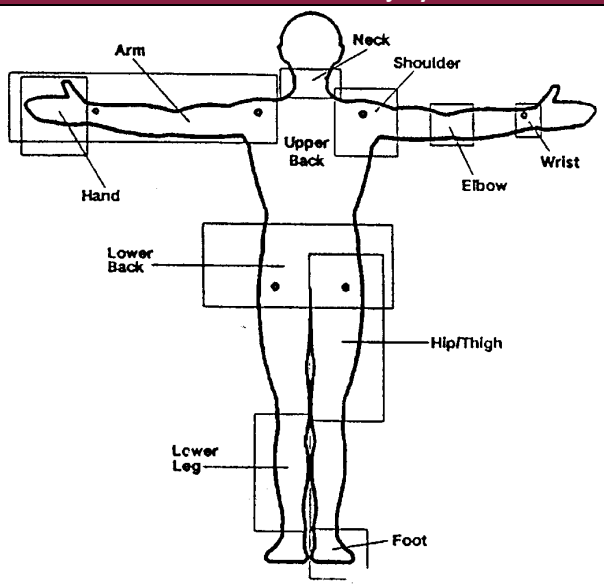
Employee Report of Injury

Name: _____ **Address:** _____
Phone #: _____ Birth Date: _____ Date of Hire: _____
Accident Occur on Premises: ☐ Yes ☐ No Detailed Location: _____
Date of Injury: _____ Time: _____ ☐ am ☐ pm Shift: _____
Date Reported: _____ **Witnesses:** _____

What were you doing just before incident occurred: _____

Describe the accident in detail/what happened: _____

What object or substance directly harmed the employee: _____

Injured Area	Indicate Area of Injury	Type of Injury
1 ☐ Head 2 ☐ Eye: L/R 3 ☐ Shoulder L/R 4 ☐ Arm L/R 5 ☐ Elbow L/R 6 ☐ Wrist L/R 7 ☐ Hand L/R 8 ☐ Finger: Specify _____ 9 ☐ Back 10 ☐ Chest 11 ☐ Abdomen 12 ☐ Pelvis 13 ☐ Hip L/R 14 ☐ Leg L/R 15 ☐ Knee L/R 16 ☐ Ankle L/R 17 ☐ Foot L/R 18 ☐ Toe: Specify _____ 19 ☐ Other: _____	 **LEFT** **RIGHT**	1 ☐ Abrasion 2 ☐ Amputation 3 ☐ Bite: _____ 4 ☐ Bruise 5 ☐ Burn 6 ☐ Concussion 7 ☐ Cut/Laceration 8 ☐ Foreign Body 9 ☐ Fracture 10 ☐ Hearing Impaired 11 ☐ Infection 12 ☐ Pain: _____ _____ 13 ☐ Puncture 14 ☐ Rash/Dermatitis 15 ☐ Respiratory 16 ☐ Strain/Sprain 17 ☐ Other: _____ _____

Employee's suggested action to prevent recurrence: _____

Employee Signature: _____ Date: _____

IMMEDIATE ACTIONS: Prior to resuming work following incident:

Any unsafe conditions with equipment or process that caused accident: ☐ Yes ☐ No Supervisor Signature _____
If yes, list condition and corrective actions to eliminate the conditions: _____

THIS PAGE MUST BE COMPLETED AND SUBMITTED PRIOR TO LEAVING YOUR SHIFT