Report by Injured Employee

Employee Name: _____

Address _____
City State Zip

Home Phone Number: _____ Date of Birth _____

Social Security Number: _____ Age: _____

Date of Hire: _____ Date of Injury: _____ Time: _____

Did you report this injury immediately to your supervisor? _____ If no, why not _____

_____ When did you report this injury? _____

Are you currently seeking medical treatment other than district specified physician? _____

If yes, give Doctor's name, address, and phone number: _____

_____

On what date did you begin seeking medical treatment? _____

How did your injury occur? _____

_____

What specifically were you doing at time of injury? _____

_____

_____

Please name the substance or object that caused your injury _____

_____

Describe in detail the nature and extent of injury, indicate the body part involved _____

_____

Were there any witnesses? If yes, please list _____

_____

Any additional comments _____

_____

_____ _____
Date Employee Signature