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| --- | --- |
| **Employee Information** | |
| **Employee Name:** | **Job Title:** |
| **Employee ID:** | **Phone Number:** |
| **Division:** | **Home Address:** |

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| **Incident Information** |
| **Date of Injury:** |
| **Time of Injury:** |
| **Location Where Injury Occurred:** |

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| **Provide a detailed account of the incident that resulted in the injury in the space provided** |
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| **What type of injury was sustained, and how severe?** |
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| **If possible, what could have been done to prevent the injury?** |
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| --- | --- |
| **Did you require first aid or other medical care for your injury?** | |
| * **Yes** | * **No** |

**\*If first aid or medical care was required, please fill in the following information:**

|  |
| --- |
| **First Aid** |
| **Name of Person Who Administered First Aid:** |
| **Contact Information (If Available):** |

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| --- |
| **Medical Care** |
| **Physician Name:** |
| **Location of Medical Facility:** |
| **Contact Information of Medical Facility:** |

|  |  |
| --- | --- |
| **Were there any witnesses present at the time of injury?** | |
| * **Yes** | * **No** |

**\*Please fill in the names and contact information of any witnesses:**

|  |
| --- |
| **Witness Name(s):**  **Witness Contact Information:** |

|  |  |
| --- | --- |
| **Employee Signature:** | **Date Signed:** |
| **Supervisor/ Manager Signature:** | **Date Signed:** |