Employee Report of Injury Form [Company Logo]

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

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

Provide a detailed account of the incident that resulted in the injury in the space provided

What type of injury was sustained, and how severe?

If possible, what could have been done to prevent the injury?

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):

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:**