Injury Report

If you experience a work-related injury or illness, you **must** complete and submit this Injury Report to the designated Human Resources Contact as listed below as soon as possible – and **NO LATER THAN** 24 hours after the injury or illness occurred. The Department of Labor requires notice of workplace injuries and because this important information is time-sensitive, you are asked to please follow the procedure listed below for reporting accidents and incidents. Thank you!

Emergency

1. The nearest witness or bystander calls 9-1-1. By dialing 9-1-1, the injury or illness is also reported to Public Safety. Please proceed to the nearest hospital emergency room or treatment facility.
2. Public Safety will then notify your supervisor and Human Resources of the injury or illness.
3. Both you and your supervisor, along with any witnesses to the incident, must complete this Injury Report and submit to the designated Human Resources Contact as listed below within 24 hours.

Non-Emergency

1. Notify your supervisor immediately of your injury or illness. Your supervisor will notify the designated Human Resources Contact.
2. If medical treatment is necessary, you may choose to visit your primary care physician for medical attention. Alternatively, you may contact one of the Occupational Health Centers listed below to set up an appointment for treatment. **Please alert your treating physician that your injury or illness is work-related!**
3. Both you and your supervisor, along with any witnesses to the incident, must complete this Injury Report and submit it to Human Resources within 24 hours.

After the Injury Report has been received, Human Resources will submit your claim to our Workers Compensation insurance carrier. Once your injury report has been processed by the carrier, you will receive a memo containing important information regarding your claim, including your claim number, which you should then provide to your treating physician.

Human Resources Contact: _____

Occupational Health Centers

Please call ahead to any of the centers listed below to ensure the facility is ready for your arrival UNLESS the injury or illness is an emergency – in that case, GO TO THE CLOSEST EMERGENCY ROOM!

_____

_____

_____

Workers Compensation Insurance Carrier

_____

Injury Report

Employee

SECTION 1: EMPLOYEE INFORMATION (all fields required)

First Name	M.I.	Last Name		SSN
Street		City	State	Zip
Home/Cell Phone		Date of Birth	Gender	Marital Status

Job Title	Department		Date of Hire
Hours Worked per Day	Days Worked per Week	Hours Worked per Week	Hourly Wage/Annual Salary

SECTION 2: ACCIDENT & INJURY INFORMATION (provide as much detail as possible)

Date of Accident	Time of Accident	Location of Accident

Explain the accident. How did it occur? What activity were you engaged in when the accident occurred? Please be specific and provide as many details as possible.

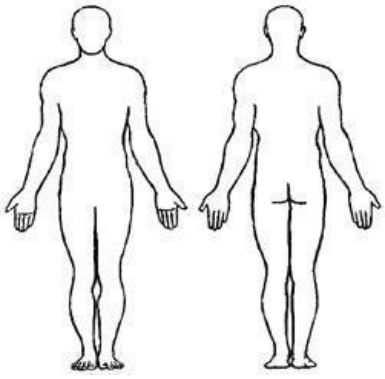
What object or substance caused the injury or directly harmed you?	What equipment was being used at the time of accident?
Who did you report the accident to?	When was the accident reported?
Witness Name(s)	Witness Phone Number(s)

Type of Injury or Illness
Did you seek medical treatment?
If yes, where was the medical treatment provided?
Date and Time of Treatment
Did you leave work early on the day of the accident?
Did you miss time from work?
If yes, how many days did you miss?
Date Returned to Work

Body part(s) affected/injured (circle on diagram)

	L	R
Eyes/Ears/Face	☐	☐
Neck/Shoulders/Arms/Elbows	☐	☐
Hips/Legs/Knees	☐	☐
Wrist/Hands/Fingers	☐	☐
Ankles/Feet/Toes	☐	☐
Back (Upper/Lower)	☐	
Head	☐	
Internal Organs	☐	

Other: _____



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If the employee was unable to complete this form, who completed it on his or her behalf?

Employee Signature	**Date**

Injury Report
Supervisor

Employee First Name	Employee Last Name	
Employee Job Title	Employee Department	
Date of Accident	Time of Accident	Location of Accident

Had the injured employee been properly instructed in safe and efficient methods? ☐ Yes ☐ No
*If yes, when?*_____

Did the injured employee violate any instructions? ☐ Yes ☐ No
*If yes, which instructions were violated?*_____

_____

Was the necessary protective equipment being worn? ☐ Yes ☐ No

Did hazardous conditions contribute to the injury? ☐ Yes ☐ No

Did horseplay cause the injury? ☐ Yes ☐ No

Was the injury caused by something that needed repairs? ☐ Yes ☐ No

Was the injury caused by an unsafe act or behavior? ☐ Yes ☐ No

Did the employee report the injury to you, the supervisor, immediately after it occurred? ☐ Yes ☐ No
*If no, when was the injury reported to you?*_____

Please describe what the injured employee was doing at the time of the accident, what happened, who was involved, and the nature of the injury.

Did the injured employee or another person do something incorrectly?

What unguarded or unsafe condition of machinery, equipment, building or premises was involved?

After the injury, what did the supervisor and/or employer do to correct the conditions that caused the injury?

What should the employer do to prevent injuries like this from occurring in the future?

Did the employee go to the doctor or hospital? ☐ Yes ☐ No

Has the employee lost time from work? ☐ Yes ☐ No

Has the employee returned to work? ☐ Yes ☐ No

Supervisor Name	Supervisor Title	Supervisor Phone Number
Supervisor Signature	Date	

Injury Report
Witness

Employee First Name		Employee Last Name
Date of Accident	Time of Accident	Location of Accident

Explain the accident and what you witnessed. How did the accident occur? What activity was the employee engaged in when the accident occurred? Describe your actions before, during, and after the accident occurred. Please be specific and provide as many details as possible.

Please provide any additional comments, details and information about the accident.

If you recall any additional details or information related to the accident after submitting this form, please contact the Office of Human Resources at (603) 897-8717.

Witness Name	Witness Title	Witness Phone Number
Witness Signature		Date