Employee Injury Report

This report must be completed by the injured employee and submitted to the Safety Department within 24 hours. FAX # 660-886-3452

1

Job Name/Location	Department	Today's Date
Date/Time of Incident ☐ A.M. ☐ P.M.	Date/Time Reported ☐ A.M. ☐ P.M.	
Who Did You Report Your Injury To?	Your Supervisor's Name at the Time the Injury Occurred	

2

Employee Injury: Describe the affected part of the body - type of injury/illness, sprain, burn, cut, etc.

Name (Last, First, MI) & Employee #		Position
Address		Date of Hire
City, State, Zip Code	Date of Birth	Telephone # (Home) / (Cell)
Type of Injury or Illness	List All Injured Body Parts - Left / Right	
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced		# of Dependents
# Days Worked Per Week	Time You Started Work ☐ A.M. ☐ P.M.	Work Status: ☐ Full Time ☐ Part Time ☐ Temporary
What Object or Substance, if any, Directly Harmed You?		Your Email Address
Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No		Were They Used? ☐ Yes ☐ No

3

Witness Information

4

Detailed Incident Description

Describe in your own words the events that led to the incident (Describe what happened, who was involved, the exact location, all equipment/tools involved. BE SPECIFIC - use additional paper if necessary.)

Created November, 2010

5

Report Completed by: (Sign and Print Name)	**Date:**

Notify the Safety Department IMMEDIATELY of all accidents