

WORKERS' COMPENSATION INCIDENT REPORT

Print Employee's Name	Today's Date
Personnel # Phone where you can be reached	
Employer	Supervisor
INCIDENT INFORMATION	
Date of Injury Time	□ □am □pm Date Reported
To Whom Reported? Did you	miss time from work for the injury? □Yes □No
If yes, give dates and times	
Returned to Work? □Yes/□No □Full Duty/□Light Du	ty If no, date expect to return?
What part of your body was injured? (Right leg, left ar	m)
What is the injury? (Cut, Sprain, Bruise)	
Explain in detail how the injury occurred?	
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Where did the injury occur? (Physical location)	
Any Witnesses? □Yes □No If yes, give names _	
Did you seek medical treatment? □Yes □No If yes, give date & time	
Doctor's name Return visit date	
What type of treatment are you getting?	
How are you getting along now?	ļ
Have you ever injured this part of your body before? □Yes □No If yes, explain when, how and to what extent:	
What would you do to prevent this from happening again?	
Signature of Employee	Date