

# INJURY REPORT FORM

Name of Injured \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

Local Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Permanent Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
(If different than local address)

Telephone Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

SSN \_\_\_\_\_

Name (s) of Witness \_\_\_\_\_

Telephone Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

### Statement of Injured Person or Witness

A. (If injured person or witness is unavailable, information is to be completed by individual completing report.)

Date of Accident \_\_\_/\_\_\_/\_\_\_ Time \_\_\_\_ AM \_\_\_\_ PM \_\_\_\_

Location of Accident \_\_\_\_\_

Summarize how injury, illness, or exposure occurred \_\_\_\_\_  
\_\_\_\_\_

Kind of injury \_\_\_\_\_

Part of Body Affected (specific part of the body i.e., left wrist, right leg) \_\_\_\_\_  
\_\_\_\_\_

Signature of Injured Person or Witness \_\_\_\_\_  
\_\_\_\_\_

### To be completed by First Aid Provider

B. Symptoms and complaints of the injured person \_\_\_\_\_  
\_\_\_\_\_

Describe the nature and extent of injury you observed \_\_\_\_\_  
\_\_\_\_\_

Treatment, recommendations, and referral  
\_\_\_\_\_  
\_\_\_\_\_

Signature of First Aid provider \_\_\_\_\_  
\_\_\_\_\_

### To be completed by Supervisor for Employee Injury/Illness (Attach additional information if necessary)

C. Evaluation of how accident occurred/contributing factors \_\_\_\_\_  
\_\_\_\_\_

Possible Preventative Actions (actions that have been/will be taken to prevent recurrence) \_\_\_\_\_  
\_\_\_\_\_

**MUST BE COMPLETED AND RETURNED WITHIN 24 HOURS OF ACCIDENT**