



EMPLOYEE REPORT OF INJURY FORM

TO BE COMPLETED FOR ALL WORK-RELATED INJURIES AND ILLNESSES

* All boxes must be filled in order to comply with state regulations.

TO BE COMPLETED BY INJURED EMPLOYEE: (please print)

Full Name			Today's Date	
Home Address			Social Security #	
City, State, Zip			Date of Birth	
Home Phone #	Work Phone #	Sex	Marital Status	
What is your current position?			Date of Injury	
What department do you work for?			Time of Injury	
Who is your supervisor?	Supervisor's title		Supervisor's Phone #	
What job were you performing at the time of the injury?				
Where did the injury take place?				
In your own words, please explain what happened? (PLEASE BE SPECIFIC)				
What specific parts of your body were injured and what is the nature of the injury?				
Have you ever been under a doctor's care for the same or similar injury?				
What machine, tool, or object was most closely connected with the injury, if applicable?				
Was the injury caused by someone or something outside the college? (Please explain)				
List the names of anyone witnessing your injury:				
Do you have any other employment? If so, where?				
To whom did you report the injury?				
When did you report it? If not immediately, please explain.				
Employee Signature			Date	

TO BE COMPLETED BY SUPERVISOR:

Medical facility where employee was sent:		Employee Date of Hire	Is employee full or part time?
Has employee returned to work?	Date returned to work:	Average number of hours the employee works each week:	Employee's hourly or weekly wage:
Supervisor Comments:			
Supervisor Signature			Date