EMPLOYEE INJURY/ILLNESS REPORT FORM

Employee Name (First, Middle, Last)	Sex ☐ M ☐ F	Employee Home Telephone No. ( )

Employee Home Street Address	City	State	Zip Code	Occupation

Birth Date	Date of Hire	County and State where incident or exposure occurred

Injury Date Mo / Day / Yr	Time of Injury ☐ am ☐ pm	Last Day Worked Mo / Day / Yr	Date Employer Notified Mo / Day / Yr	Shift working at time of incident (i.e., 7:00 – 4:00)	☐ Did you leave work? ☐ Estimated Date of Return

Hours worked prior to injury	Location where injury occurred – be as specific as possible.

Were you or do you anticipate being treated by a medical professional for this injury or illness? ☐ Yes ☐ No

Were you hospitalized for this injury or illness? ☐ Yes ☐ No

Name and address of medical professional and/or hospital:

AREA INJURED

1 ☐ **Head**
2 ☐ **Eye** L ☐ R ☐
3 ☐ **Back**
4 ☐ **Shoulder** L ☐ R ☐
5 ☐ **Arm** L ☐ R ☐
6 ☐ **Elbow** L ☐ R ☐
7 ☐ **Wrist** L ☐ R ☐
8 ☐ **Hand** L ☐ R ☐

9 ☐ **Finger: Specify**

10 ☐ **Chest**
11 ☐ **Abdomen**
12 ☐ **Pelvis**
13 ☐ **Hip** L ☐ R ☐
14 ☐ **Leg** L ☐ R ☐

15 ☐ **Knee** L ☐ R ☐
16 ☐ **Ankle** L ☐ R ☐
17 ☐ **Foot** L ☐ R ☐
18 ☐ **Toe: Specify**

19 ☐ **Other**

TYPE OF INJURY

1 ☐ **Abrasion**
2 ☐ **Amputation**
3 ☐ **Bite**
4 ☐ **Bruise**
5 ☐ **Burn**
6 ☐ **Concussion**
7 ☐ **Cut / Laceration**
8 ☐ **Foreign Body**
9 ☐ **Fracture**
10 ☐ **Hearing Impaired**
11 ☐ **Infection**
12 ☐ **Pain**
13 ☐ **Puncture**
14 ☐ **Rash / Dermatitis**
15 ☐ **Respiratory**
16 ☐ **Strain / Sprain**
17 ☐ **Other**

Employee Account of Injury: Describe your activities when injury or illness occurred and what tools, machinery, objects, chemicals, etc. were involved.

What happened to cause this injury or illness? (Describe how the injury occurred).

Describe your injury or illness. (State the part of body affected and how it was affected).

In your opinion, list the ways a similar occurrence could be prevented in the future. (e.g., equipment, training, procedures, etc.)

☐ Additional Page(s) attached.

Witness(es) – Names of all employees and non-employees who witnessed your injury or illness. (Use additional page if necessary).

Employee Signature:	Date Signed
Supervisor Signature:	Date Signed

SUPERVISOR INVESTIGATION OF INJURY/ILLNESS

Employee Name (First, Middle, Last)	Injury Date Mo / Day / Yr

This form is to be completed by the employee's supervisor or departmental manager. Please provide information that will supplement the employee's report, noting circumstances which may have contributed to the injury or illness, such as weather conditions, use of protective safety equipment, etc. Be thoughtful and thorough, seeking to identify operations, procedures, use of equipment or modification that could help reduce future incidents.

UNSAFE ACT / CONDITION:

- ☐ **Housekeeping**
- ☐ **Work Practices**
- ☐ **Safeguarding devices**
- ☐ **Physical and environmental stresses**
- ☐ **Facility / design**
- ☐ **Materials / tools**
- ☐ **Hazards not recognized**
- ☐ **Protective equipment**
- ☐ **Exceeding limits (speeds, strengths, etc.)**

☐ **Other:** _____

_____

CONTRIBUTING FACTORS:

- ☐ **Equipment failure**
- ☐ **Used wrong equipment**
- ☐ **Housekeeping / Maintenance**
- ☐ **Procedure Factors**
- ☐ **Improper Body Mechanics (ie: Improper Lifting, carrying)**
- ☐ **Slippery or defective floor / work surface**
- ☐ **Knowledge / skills lacking**
- ☐ **Substance abuse**
- ☐ **Repetitive Motion / Ergonomic**
- ☐ **Work Station / Ergonomic**
- ☐ **Failure to use protective equipment / devices**
- ☐ **Safety Policy / Rule Violation**
- ☐ **Unsafe Act**
- ☐ **Environmental exposure to toxic substance, noise, etc.**
- ☐ **Horseplay**

☐ **Other:** _____

_____

CORRECTIVE ACTION (Attach additional pages, if necessary):

Action to be Taken to Prevent Recurrence:	Responsible Party:	Completion Date:
1		
2		
3		

☐ **Photos Attached.**

Supervisor Signature:	Date Signed
Department Manager Signature:	Date Signed