REPORT OF INJURY FORM
(TO BE COMPLETED BY THE EMPLOYEE)

NAME _____ DATE: _____

DATE OF BIRTH: _____ DATE OF ACCIDENT: _____

TIME OF ACCIDENT: _____

S. S. # _____ POSITION: _____

DEPARTMENT_____

DESCRIBE IN FULL HOW THE INJURY OCCURRED:

EMPLOYEE SIGNATURE; _____

SUPERVISOR: HAVE THE EMPLOYEE COMPLETE AT THE TIME OF INJURY OR ILLNESS AND RETURN TO HUMAN RESOURCES.