# REPORT OF INJURY FORM

(For reporting work-related injuries/illnesses)

**The injured worker and supervisor must complete and file this report with the Human Resources WITHIN 24 HOURS of any on-the-job injury.**

| **PART A: INJURED WORKER'S STATEMENT OF ACCIDENT/ILLNESS** | | | |
|---|---|---|---|
| Employee Name (Last Name, First Name): | | | Employee ID #: |
| Home address: | | | SSN: |
| Home phone: | Date of Birth: | | Work phone: |
| Job Title: | Department Name: | | |
| Date of occurrence: | Time of accident: | Location of injury occurrence: | |
| How was injury incurred: | | Time employee began work: | |
| Were you ever treated for a similar condition before: | | Body part(s) injured: | |
| If yes, give details: | | | |

**Employee's Signature:**_____ **Date:**_____

| **Part B: SUPERVISOR'S STATEMENT** | | |
|---|---|---|
| Injury: | | Payroll Location: |
| Name and address of hospital or physician: | Did injured worker receive medical treatment: | Date: |
| Object or machinery causing injury: | | |
| Was there contact with any other person's blood or body fluid: | | |
| If yes, name and address of source person: | Did weather conditions contribute to occurrence: | |
| How could a similar occurrence be avoided: | If yes, what were the weather conditions: | |
| Describe any unsafe practice: | | |
| Name and phone number of witnesses (if any): | | |
| Did injured worker lose time from work: | If yes, first full day of disability: | |
| Has the injured worker returned to work: | If yes, date returned: | |

**IF THE INJURED WORKER RETURNS TO WORK OR BECOMES DISABLED AFTER THIS FORM HAS BEEN FILED, IT IS IMPERATIVE HUMAN RESOURCES BE CALLED IMMEDIATELY.**

| Supervisor's Name: | Signature: |
|---|---|
| Phone ext: | Date Completed: |

**Original and one copy of the Report of Injury Form are needed.**

1. **Original to: Human Resources**

2. **Copy to be retained for department records.**

**Part A is to be completed by the injured worker immediately after he/she has reported any on-the-job injury to his/her supervisor. All questions must be answered. The employee's signature is required.**

**Part A is to be verified by the Supervisor.**

**Part B is to be completed and signed by the supervisor. Discuss the occurrence in detail with the injured worker prior to completing this section. If you have any valid reason to believe the occurrence did not happen as described, use the word "Alleged" in your description of injury.**

**If you have any questions regarding the filing of this form, contact Human Resources.**