# Workplace Injury Report Form

INSTRUCTIONS: Employees shall report all work- related accidents, injuries, illnesses- or unplanned events which could have resulted in an injury or illness- using this form. Once completed this form shall be given to a manager for next steps.

| I am reporting a work related: (please check the appropriate box) | | Injury | | Illness |
|---|---|---|---|---|

| Employee Name | Social Security Number | Date of report |
|---|---|---|
| | | |

| Job Title | Date of Birth | Home Address |
|---|---|---|
| | | |

| Location of Incident | Date of Incident | Time |
|---|---|---|
| | | |

**Witness if any**

**Incident Description- Describe tasks being performed and sequence of events. Attach additional page if necessary**

**What could have been done to prevent this injury/illness**

**What parts of your body were injured?**

**Was Medical Treatment necessary?** **If yes, name of hospital/physician**

| | **Yes** | | **No** | |
|---|---|---|---|---|

| Date of Visit | Time of Visit | Hospital/physician phone # |
|---|---|---|
| | | |

| **Has this part of your body been injured before?** | | **Yes** | | **No** | **If yes, when?** | |
|---|---|---|---|---|---|---|
| **Do you have other employment?** | | **Yes** | | **No** | **Company Name** | |

| Employee Signature | Date | Manager Signature | Date |
|---|---|---|---|
| | | | |