Workers' Compensation
Employee's Report of Injury
(To be completed by the employee only.)

Employee's Name: _____ Male___ Female____
Last First Middle

Date of birth: ___/___/____ Home telephone# (_____) _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Present classification: _____ How long employed here: _____

Social Security No.: _____-_____-_____ Weekly salary: _____

Location of accident: _____
Address Area (loading dock, bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident):
_____
_____
_____

_____

Describe bodily injury sustained (be specific about body part(s) affected): _____
_____

_____

Recommendation on how to prevent this accident from recurring: _____
_____

Name of supervisor: _____ Phone#_____
Last First

Name(s) of witness(es):_____Phone#_____
(Attach witness(es) report(s)

When did you report the accident to your supervisor? _____

To whom did you report the injury? _____

Do you require medical attention? Yes: _____ No: _____ Maybe: _____

Name of your treating physician: _____ Phone#_____

Signature of employee: _____ Date: _____