

INJURY REPORT / INVESTIGATION FORM

DEPT. HEAD

EMPLOYEE'S NAME	MARITAL STATUS	SEX: <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS	SOC. SEC. NO.	
DATE OF BIRTH	TELEPHONE NO.	STATE COUNTRY
DATE OF INJURY	TIME	DATE INJURY REPORTED
DATE HIRED	WAGE/SALARY	DAYS WORK PER WEEK S M T W TH F S

EMPLOYEE

DID YOU HAVE AN ACCIDENT ON COMPANY PREMISES: YES NO
TO WHOM WAS THE ACCIDENT REPORTED?
SPECIFY WORK AREA WHERE ACCIDENT OCCURRED:
DESCRIBE HOW ACCIDENT OCCURRED: (WHAT, HOW, OBJECT OR SUBSTANCE INVOLVED)
EMPLOYEE'S SIGNATURE: DATE:

PRELIMINARY MEDICAL	BODY PART	TYPE	
DISABLING INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	EYE	LACERATION	
SENT TO HOSPITAL YES NO	HEAD	ABRASION	
SENT TO COMPANY DOCTOR/NURSE YES NO	CHEST	PUNCTURE	
RETURN TO REGULAR JOB YES NO	BACK	BURN	
RETURN TO LIGHT DUTY JOB YES NO	ABDOMEN	FRACTURE	
RECORDABLE ON OSHA FORM 200 YES NO	ARM	STRAIN-SPRAIN	
EST. DAYS OF DISABILITY	HAND-FINGER	AMPUTATION	
DATE TO RETURN TO WORK	LEG	FOREIGN BODY	
INITIAL MEDICAL DIAGNOSIS	FOOT-TOE	HERNIA	
NAME AND ADDRESS OF HOSPITAL	RESPIRATORY	CONTUSION	

SUPERVISOR'S DESCRIPTION

DEPARTMENT HEAD SIGNATURE: _____ DATE _____