EMPLOYEE STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS

EMPLOYEE PERSONAL INFORMATION

EMPLOYEE NAME: _____ EMPLOYMENT SITE: _____

HOME ADDRESS: _____ PHONE NUMBER: _____

JOB TITLE _____ DATE OF BIRTH: _____

_____ SOCIAL SECURITY #: _____

HOURS PER DAY _____ WORK DAYS (CIRCLE) SUN M T W TH F SAT

PLEASE ANSWER ALL THE QUESTIONS BELOW AND SUBMIT TO YOUR SUPERVISOR.

1. DATE OF INJURY/ILLNESS: _____ DATE REPORTED:_____
2. TIME YOU BEGAN WORK: _____ ☐ AM ☐ PM TIME OF INJURY: _____ ☐ AM ☐ PM
3. EXACT LOCATION WHERE INJURY/ILLNESS OCCURRED: _____
4. DEPARTMENT/SITE WHERE EVENT OCCURRED: _____
5. PLEASE STATE SPECIFIC PART OF BODY AFFECTED AND TYPE OF INJURY: _____
6. PLEASE STATE EQUIPMENT, MATERIALS AND/OR CHEMICALS BEING USED WHEN INJURY OCCURRED
7. EXPLAIN THE CIRCUMSTANCES AND/OR ACTIVITY RELATED SPECIFICALLY TO THE INJURY/ILLNESS. DESCRIBE THE SEQUENCE OF EVENTS THAT LED TO THE INCIDENT THAT DIRECTLY AFFECTED THE INJURY/ILLNESS (USE BACK OF FORM IF NECESSARY.) _____
8. WAS ANYONE ELSE INJURED? ☐ NO ☐ YES: (IDENTIFY) _____
9. WHO DID YOU NOTIFY REGARDING THIS ACCIDENT/ILLNESS: _____
10. PLEASE NAME ANY WITNESSES: _____

SIGNATURE _____ DATE _____