Employee Report of Injury

(To be filled out with Supervisor within 24 hours of accident/injury)

Employee Name:	D.O.B.:	
Address:		
City:	State: Zip:	
Phone Number:	Social Security:	
Occupation:	Work Schedule:	7.20
Work Site:		to when: 7:30am – 4:30pm)
Site of Accident/Injury:		
Date of Accident:	Time of Accident:_	am/pm
	ened (sidewalk, classroom, gym, etc.):	
Describe <u>how</u> the accident occurre	d (be specific):	
Describe injury (cut on right hand, spre	ained left ankle, etc.):	
Witnesses or other persons involve	ed:	
How might the injury been preven	ted?	
Date of this Report:		
Employee's Signature:		