



Work Related Injury Report Form
EMPLOYEE REPORT OF INJURY

Employee Name: _____ Employee ID # _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____ Phone #: _____

Alternate Phone #: _____ Work Phone #: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Number of Days Per Week Worked: _____ Normal Days Off: _____

Number of Hours Worked Per Day: _____ Current Hourly Rate of Pay: \$ _____

If you have dependent children under 21 years of age (or under the age of 25 and attending school full time) living with you complete the following:

Dependent Name: _____ Age: _____

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Dependent Name: _____ Age: _____

Are any of the above dependent children not supported at least 50% by you? _____ If yes, identify names: _____

Date of Injury: _____ Time: _____ Date Reported: _____

Accident Reported To: _____

Accident Reported By (name): _____

Who Witnessed the Accident: _____

Describe Fully How Injury Happened: _____

(continued on reverse side)

What Part(s) of Your Body Were Injured? _____

Did You Stop Work as a Result of Your Accident? _____ If Yes, When: _____

If Not Working, When Do You Expected to Return to Work? _____

If you were off work but have returned when did you return? _____

From Whom Did You Receive Medical Treatment? _____

Date of Treatment: _____ Are You Still Under Treatment? _____

How Often Do You Receive Treatment? _____

Name of Doctor Treating You: _____

Address of Doctor: _____

Phone Number of Doctor: _____

This form should be completed and returned to Human Resources (Ann Hargenrader) as soon as possible but no later then 48 hours following the accident.

FOR HUMAN RESOURCES OFFICE USE ONLY

Date Form Provided To Employee: _____ By: _____

Supervisor Form _____ Provided to Employee _____ Sent to Supervisor

Date Form Returned to Human Resources: _____ To: _____

Date Entered Into Inservco FROI System: _____ By: _____

Lost Time: _____ Yes _____ No

Hourly Wage: _____

NOTES: _____
