

EMPLOYEE'S FIRST REPORT OF INJURY FORM

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INSTRUCTIONS Employees shall report all work-related accidents, injuries, illnesses - or unplanned events which could have resulted in an injury or illness - using this form. Once completed, this form shall be given to a manager for next steps.

I AM REPORTING A WORK RELATED:	<input type="checkbox"/>	INJURY	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>	NEAR MISS
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YOUR NAME	SUPERVISOR NAME	DATE OF REPORT
<input type="text"/>	<input type="text"/>	<input type="text"/>

JOB TITLE	Has your supervisor been made aware of this incident?
<input type="text"/>	<input type="text"/>

LOCATION OF INCIDENT	DATE OF INCIDENT	TIME
<input type="text"/>	<input type="text"/>	<input type="text"/>

WITNESSES *if any*

<input type="text"/>

INCIDENT DESCRIPTION Describe tasks being performed and sequence of events. *Attach additional pages as necessary.*

<input type="text"/>

What could have been done to prevent this injury / near miss?

<input type="text"/>

What parts of your body were injured? If a near miss, how could you have been hurt?

<input type="text"/>

Was medical treatment necessary?		IF YES, NAME OF HOSPITAL / PHYSICIAN:	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="text"/>	
DATE OF VISIT	TIME OF VISIT	HOSPITAL / PHYSICIAN PHONE	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Has this part of your body been injured before?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, when?	<input type="text"/>
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Do you have other employment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Company Name	<input type="text"/>
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EMPLOYEE SIGNATURE	DATE	SUPERVISOR SIGNATURE	DATE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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