

Employee Injury Investigation Report

Employee Name (last, first, middle): _____ SS#: _____

Employee Address (city, state, zip): _____ Phone #: _____

Employee Information: Male Female Birth Date: _____

Employee Department: _____ Job Title: _____ Hire Date: _____

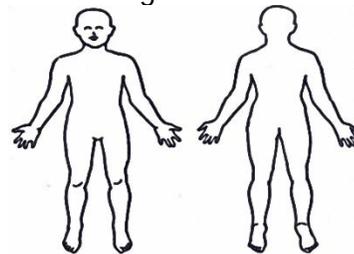
Supervisor: _____ Shift: 1 2 3 Other

Date of Accident/Injury: _____ Time: _____ am/pm Day occurred: S M T W TH F S

Location of Accident/Injury: _____ Who was notified? _____

Describe Accident/Injury (*describe what happened, how the Accident/Injury occurred. Include details pertaining to equipment, environment, tasks, etc.*):

Indicate on the Diagram the location of injury:



Body Part Injured: _____

Injury is an: New or Re-injury

****Use reverse side for additional information if needed****

Was first aid administered? No Yes When? _____ By Whom? _____

Medical treatment required? No Yes If yes, where? _____

Did this injury involve lost time from work? Yes No If yes, estimate number of days/hours: _____

Do you intend to seek additional medical care for this injury? No Yes By Whom? _____

Is this an aggravation of a previous injury? Yes No

Have you ever had a similar injury? Yes No

What was the cause of this accident/injury? _____

How could this accident/injury have been prevented? _____

Did anyone witness the accident/injury? No Yes Name(s): _____

Do you have other employment? No Yes Where? _____

I have been offered outside medical treatment for the accident/injury indicated in this report and I have declined to go to treatment at this time.

Employee's Signature: _____ Date: _____