INJURY REPORT FORM

Location of Incident: ____________________ Time of Incident: ____________

Employee Information:

Full Name: ____________________

Employee ID / SSN: ____________________

Department / Job Title: ____________________

Supervisor Name: ____________________

Incident Details:

Date of Incident: ____________________ Time: ____________

Location (Specific): ____________________

Description of Incident:

Injury Details:

Nature of Injury: ____________________

Part(s) of Body Injured: ____________________

Was First Aid Administered? ____________________

Name of First Aid Provider: ____________________

Was Medical Treatment Required? ____________________

Witness Information:

Witness 1 Name: ____________________ Contact Info: ____________

Witness 2 Name: ____________________ Contact Info: ____________

Employee Statement:

Supervisor Review and Comments:

Signatures:

This report is executed pursuant to applicable United States laws and regulations. All parties affirm that the information provided herein is true and accurate to the best of their knowledge. This document may be used as evidence in legal and administrative proceedings. Unauthorized alterations or falsifications may constitute a criminal offense.

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