Occupational Injury Worksheet

Employee's Name:	Social Security #:
Address:	Phone Number:

Date of Birth:	Marital Status:	Male/Female:
Hire Date:	# of Dependents:	Yrs in Current Job:
Dept. Employed By:	Occupation:	Supervisor's Name:

Date of Injury/Accident:	Time of Accident:
Time Workday Began:	Date Employer Notified:
Place of Accident:	

Describe Nature of Injury in Detail:

Describe Employee's Activities When Injury Occurred:
List any Witnesses:

Was Safety Equipment Provided? Yes No	Was it in Use? Yes No

Could something have been done to prevent this accident? If yes, please explain:

Did you go to a Doctor? If so, Doctor's Name:
Did you go to a Hospital? If so, Hospital's Name:
Treatment Given on Site: First Aid Ambulance Called

Date:	Name of Person Filling Out Form:

Form Must Be Turned In Within 8 Hours From Time of Injury