

# EMPLOYEE'S REPORT OF INJURY

(To be completed by the employee only.)

Employee's name: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

\_\_\_\_\_ Last First Middle  
Date of birth: \_\_\_/\_\_\_/\_\_\_ Home telephone#(\_\_\_\_\_) \_\_\_\_\_

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Present classification: \_\_\_\_\_ How long employed here: \_\_\_\_\_

Social Security No.: \_\_\_\_-\_\_\_\_-\_\_\_\_ Weekly salary: \_\_\_\_\_

Location of accident: \_\_\_\_\_  
Address Area (loading dock, bathroom, etc.)

Date of accident: \_\_\_\_\_ Time of accident: \_\_\_\_\_

Describe fully how accident occurred: (including events that occurred immediately before the accident):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe bodily injury sustained (be specific about body part(s) affected): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Recommendation on how to prevent this accident from recurring: \_\_\_\_\_

\_\_\_\_\_

Name of supervisor: \_\_\_\_\_ Phone# \_\_\_\_\_  
Last First

Name(s) of witness(es): \_\_\_\_\_ Phone# \_\_\_\_\_  
(Attach witness(es) report(s))

When did you report the accident to your supervisor? \_\_\_\_\_

To whom did you report the injury? \_\_\_\_\_

Do you require medical attention? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Maybe: \_\_\_\_\_

Name of your treating physician: \_\_\_\_\_ Phone# \_\_\_\_\_

Signature of employee: \_\_\_\_\_ Date: \_\_\_\_\_

**Department of Administrative Services**  
**Risk Management Services**  
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