

Employee Incident Report

To be completed by the employee immediately following work related injury

EMPLOYER/FACILITY _____

SPECIFIC LOCATION OF INCIDENT: _____ INCIDENT DATE: _____ TIME: _____

Employee Name: _____ Title: _____

Date of Birth _____ Home Phone: _____ Cell Phone: _____

What were you doing when the incident occurred?

Please describe in detail the incident/accident and specifically which body parts were injured:

Were all proper safety and training procedures followed? Y/N ____

If not, please explain: _____

Was another employee involved in the incident? Y/N ____

If yes, what is the name of the other employee? _____

Was the accident witnessed? (Y/N) ____ Name(s) of witnesses _____

Transported to Hospital or Medical Facility: Y/N ____ If yes, by whom _____

Name of Hospital or Treating Physician: _____ Phone Number: _____

If injured was off site at the time of the incident, name of location and if transportation used, name of transporter: _____

I certify under the penalties of perjury that all statements made in this claim are true, correct, and complete to the best of my knowledge, information, and belief and that I did not suppress or withhold evidence necessary to settle this claim. I grant my employer and its representatives the right to request and obtain, from any source, any and all medical information necessary to determine my health status pertaining to my work related injury, including but not limited to return to work evaluations and necessity and frequency of medical treatment.

Employee Signature: _____ Supervisor Signature: _____

Dated: _____

Any employee who willfully and knowingly files a false workers' compensation claim or misrepresents the circumstances of their injury in order to obtain benefits will be guilty of a felony and will be prosecuted to the fullest extent of the law.