

# WORKERS' COMPENSATION INCIDENT REPORT

Print Employee's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

SS# \_\_\_\_\_ Phone where you can be reached \_\_\_\_\_

Employer \_\_\_\_\_ Supervisor \_\_\_\_\_

## INCIDENT INFORMATION

Date of Injury \_\_\_\_\_ Time \_\_\_\_\_ am / pm Date Reported \_\_\_\_\_

To Whom Reported? \_\_\_\_\_ Did you miss time from work for the injury? Yes / No

*If yes*, give dates and times \_\_\_\_\_

Returned to work? Yes / No Full Duty / Light Duty *If no*, date expect to return? \_\_\_\_\_

What part of your body was injured? (*Right leg, left arm*) \_\_\_\_\_

What is the injury? (*Cut, Sprain, Bruise*) \_\_\_\_\_

Explain in detail how the injury occurred? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Where did the injury occur? (*Physical location*) \_\_\_\_\_  
\_\_\_\_\_

Any witnesses? Yes / No *If yes*, give names \_\_\_\_\_

Did you seek medical treatment? Yes / No *If yes*, give date & time \_\_\_\_\_

Doctor's name \_\_\_\_\_ Return visit date \_\_\_\_\_

What type of treatment are you getting? \_\_\_\_\_  
\_\_\_\_\_

How are you getting along now? \_\_\_\_\_  
\_\_\_\_\_

Have you ever injured this part of your body before? Yes / No *If yes*, explain when, how, and to what extent: \_\_\_\_\_  
\_\_\_\_\_

What would you do to prevent this from happening again? \_\_\_\_\_  
\_\_\_\_\_

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_