Employee's Report of Injury

(Completion of all form fields is mandatory)

Employee's name:		Job title/Department:	
Date of Accident:		Time of Accident:	
Date of birth:		Date of Hire:	
Work number:		Cell number:	
Home address:			
	(Street address)	*(City, State)*	*(ZIP)*

Accident location:			
Supervisor Name:		Supervisor extension:	

Describe how accident occurred (including events that occurred immediately before the accident) **- REQUIRED**

Describe bodily injured sustained (be specific about body part(s) affected) **- REQUIRED**

Recommendation on how to prevent this accident from recurring – At least one recommendation is **REQUIRED**

_____ _____

Employee Signature Date

Refusal of Initial Medical Treatment

By initialing this paragraph, I acknowledge my decision NOT to seek medical treatment for the injury described above. I am aware that I can request treatment at a later date. I agree to notify my supervisor and Workers' Compensation representative prior to seeking medical attention should I choose to request treatment at a later date: *Employee Initials:* _____