

Occupational Injury or Illness Report

This form contains sections to be completed by both the supervisor and the employee.

The accident should be investigated by the supervisor of the injured employee or department involved. It should be completed soon as possible to obtain the most accurate information.

Supervisor Section										
Date of Injury:			Date Reported:			Employer Name:				
Name of Employee:				S.S. No:		XXX-XX- (last four digits)				
Home Address, City, Zip Code:										
Home Phone:			Work Ext:		Date of Birth:					
Cell Phone:										
Sex:		Occupational Title:			Date of Employment:					
Time Work Shift Began:			Time Accident Occurred:			Day of week				
AM/PM			AM/PM			M T W TH F S SU				
Location:										
Injury Type (Circle)										
25	Foreign Body in Eye			81	Animal, Insect, Human Bite			28	Fracture	
43	Cut/Puncture			46	Hernia/ Rupture			02	Amputation	
40	Abrasion/Scratches			99	Heart Attack/Stroke			68	Skin Irritation/ Dermatitis	
10	Bruise/Contusion/Crushing			72	Hearing Impairment			07	Concussion/ Loss of Consciousness	
49	Sprain/Strain			66	Exposure (Chem. Temp. Elect)			24	Death	
04	Burn (Chem, Liquid, Electrical)			81	Exposure (Blood/ Body Fluid)			00	Other	
Injury Cause (Circle)										
46	Struck by/ Against Object			31	Noise			85	Animal, Insect, Human	
25	Fall-Same Level, Different Level			98	Repetitive Motion/Trauma			84	Hot Object, Substance or Fire	
54	Jumping or Climbing			30	Slipping/Tripping			26	Caught in/Under/ Between	
48	Vehicle Accident/ Struck by Vehicle			57	Pushing/Pulling/ Lifting/ Carrying			59	Other	
Was injury caused by another person, faulty/broken equipment, a vehicle?					Yes		No			
If yes, explain:										
Body Part Injured (Circle)										
02	Head/Neck/Face/Mouth			44	Wrist (Left Right)			74	Hips/ Buttocks	
05	Eye (Left Right)			45	Hand (Left Right)			46	Fingers (Left Right) Digit:	
04	Ear (Left Right)			61	Back (Upper Lower)			83	Knee (Left Right)	
48	Shoulder (Left Right)			67	Chest/Abdomen Including internal organs			85	Ankle (Left Right)	
41	Arm (Left Right)			66	Pelvis/ Groin			86	Foot (Left Right)	
42	Elbow (Left Right)			82	Leg (Thigh Calf)			87	Toes (Left Right) Digit:	
73	Respiratory			01	Other			96	No Physical Injury	
First Aid or Medical Treatment										
Was first aid given?			Yes		No		If yes, by whom:			
Was medical treatment required by a physician or hospital?					Yes		No			
Physician/ Hospital Name, Address, and telephone number:										

Explanation of injury (How, When, Where)

Date you first noticed the pain? _____ Did this pain develop gradually? _____ Or suddenly? _____

If the pain developed suddenly, exactly what were you doing when the pain was felt?

If nothing unusual or unexpected happened, what do you think caused the pain?

List body parts injured:

Have you discussed this pain with anyone at work? If yes, with whom and when? Yes No

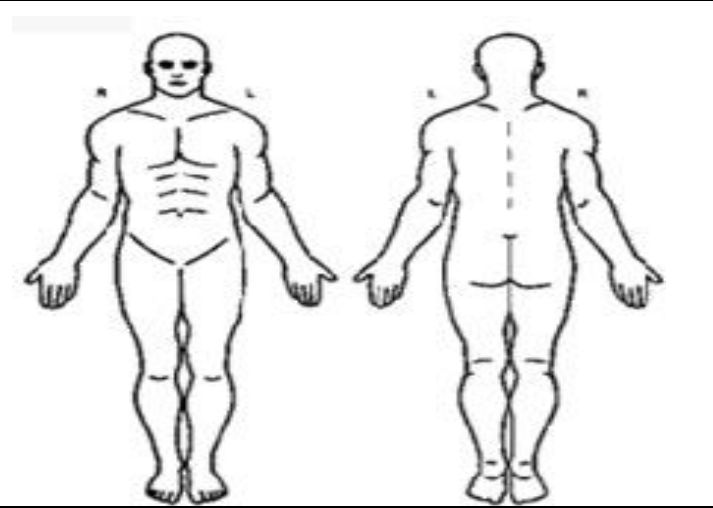
Have you had any recent non-work related injuries/illnesses? If yes, please list: Yes No

If the above answer is yes, what was the problem, when did it occur, and what (if any) medical treatment did you receive?

Show part(s) of the body injured, noting the longevity, type and degree of pain.

On the diagram below, indicate the location, description, and level of pain you are experiencing at this time.

Example: "A-6= Ache- Severe pain"



Note type of pain:		
A = Ache	B = Burning	P = Pins & Needles
N = Numbness	S = Stabbing	O = Other
Note level of pain:		
0	No Pain	
1	Mild pain, you are aware of it, but it doesn't bother you	
2	Moderate pain that requires medication to tolerate the pain	
3	More severe pain	
4	Severe pain	
5	Intensely severe pain	
6	Most severe pain, unbearable	
Was medical treatment away from the job site offered?		
Yes	No	

If treatment was offered, but declined, please sign:

Have you ever received medical treatment for the injured body part(s) listed above? If so, please note the date and physician/hospital where treatment was rendered. Yes No

Are you currently receiving Social Security **Disability** Payments (*not Social Security retirement payments*)? Yes No

Are you currently receiving Medicare assistance? Yes No

Do you currently have a Child Support Lien Yes No

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief they are correct and complete.

Employee Name: (Print) _____

Employee Signature: _____ **Date:** _____

Supervisor's Statement

As a result of your investigation, what do you believe occurred and why?

From your investigation is the validity of the accident in doubt? Yes No If yes, explain why.

Was a third party at fault? If yes, explain

Were there any witnesses? If yes, please list

Name	Address	Phone	Date

Supervisor's Signature: _____ **Date:** _____