

Worker's Compensation Incident Report

Completed by Employee

Employee's Name _____ Today's Date _____

SS# _____ Best Phone # _____

Employer _____ Supervisor _____

Incident Information

Date of Injury _____ Time of Injury _____ am/pm Date Reported _____

To Whom Reported? _____ Did you miss work for the injury? ☐ Yes ☐ No

If yes, give dates and times _____

Have you returned to work? ☐ Yes ☐ No ☐ N/A If no, date you expect to return? _____

What part of your body was injured? (ex: right leg, left arm, etc.) _____

What is the injury? (ex: cut, sprain, bruise) _____

Explain in detail how the injury occurred.

Where did the injury occur? (Physical location) _____

Any witnesses? ☐ Yes ☐ No If yes, please give names _____

Did you seek medical treatment? ☐ Yes ☐ No If yes, 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 _____

Submit to ESU 8 Business Office