

## INJURY REPORT / INVESTIGATION FORM

**DEPT. HEAD**

EMPLOYEES NAME	MARITAL STATUS	SEX: __ M__F
ADDRESS	SOC. SEC. NO.	
DATE OF BIRTH	TELEPHONE NO.	STATE      COUNTRY
DATE OF INJURY	TIME	DATE INJURY REPORTED
DATE HIRED	WAGE/SALARY	DAYS WORK PER WEEK   S M T W TH F S

**EMPLOYEE**

DID YOU HAVE AN ACCIDENT ON COMPANY PREMISES :	YES	NO
TO WHOM WAS THE ACCIDENT REPORTED?		
SPECIFY WORKS AREA WHERE ACCIDENT OCCURRED:		
DESCRIBE HOW ACCIDENT OCCURRED (WHAT, HOW, OBJECT OR SUBSTANCE INVOLVED)		
EMPLOYEES SIGNATURE:		DATE:

PRELIMINARY MEDICAL	BODY PART	TYPE	
DISABLING INJURY _YES _NO	EYE	LACERATION	
SENT TO HOSPITAL    YES    NO	HEAD	ABRASION	
SENT TO COMPANY DOCTOR/NURSE YES    NO	CHEST	PUNCTURE	
RETURN TO REGULAR JOB    YES    NO	BACK	BURN	
RETURN TO LIGHT DUTY JOB    YES    NO	ABDOMEN	FRACTURE	
RECORDABLE ON OSHA FORM 200 YES NO	ARM	STRAIN - SPRAIN	
EST. DAYS OF DISABILITY	HAND - FINGER	AMPUTATION	
DATE TO RETURN TO WORKS	LEG	FOREIGN BODY	
INITIAL MEDICAL DIAGNOSIS	FOOT-TOE	HERNIA	
NAME AND ADDRESS OF HOSPITAL	RESPIRATORY	CONTUSION	

**SUPERVISOR'S DESCRIPTION**


**DEPARTMENT HEAD SIGNATURE :** \_\_\_\_\_ **DATE** \_\_\_\_\_