Worker Injury Report

EMPLOYEE NAME:				
SSN:		DOB:		
HOME ADDRESS				
CONTACT PHONE NO:				
MARITAL STATUS: (CIRCLE ONE)	SINGLE	DIVORCED	MARRIED	
NUMBER OF DEPENDENTS:				
DATE OF HIRE:		JOB TITLE:		
GROSS PAY PER WEEK:				
DATE & TIME OF INJURY:		DATE & TIME REPORTED:		
WHERE INJURY OCCURRED:				
LOCATION OF INJURY: (RIGHT HAND, LEFT ANKLE)				
TYPE OF INJURY: (SPRAIN, LACERATION)				
ACCIDENT DESCRIPTION:				
WITNESSES AND CONTACT PHONE NO:				
TYPE OF MEDICAL TREATMENT: (CIRCLE ONE)	IN HOUSE FIRST AID	MEDICAL CLINIC	EMERGENCY ROOM	
NAME OF MEDICAL FACILITY:				
ADDRESS OF MEDICAL FACILITY				
PHONE NO OF MEDICAL FACILITY:				
SAFEGAURDS OR SAFETY EQUIPMENT USED:				
SUPERVISORS NAME & CONTACT:				

*Designated workers comp site: Doctors Care (East Main St and Blackstock Rd)

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Name of Person Completing Form | Contact Phone Number | Date