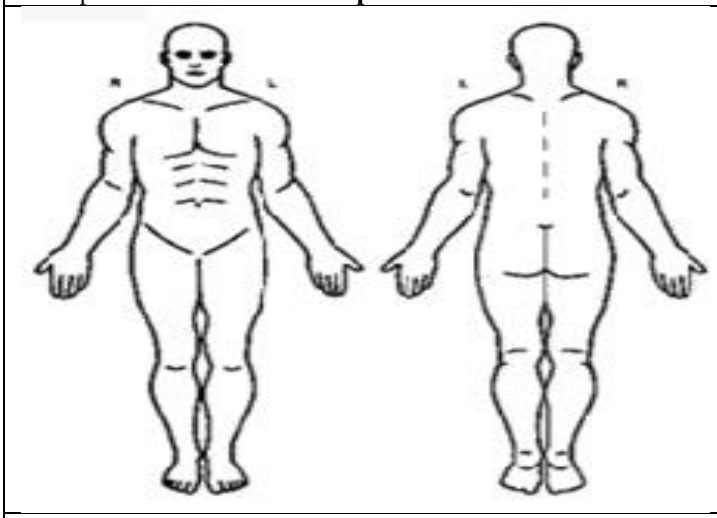
Occupational Injury or Illness **Employee** Report

It should be completed soon as possible to obtain the most accurate information.

Employee Name:	Employer:	
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	

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):	**Date of Birth:**	**Social Security Number**
Employee Signature:	**Date:**	

Occupational Injury or Illness **Supervisor** Report

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.

Date of Injury:	Date Reported:	Employer Name:
Name of Employee:	Occupational Title:	
Time Work Shift Began: AM/PM	Time Accident Occurred: AM/PM	Day of week M T W TH F S SU
Location:		

Injury Type (Circle)

Foreign Body in Eye	Animal, Insect, Human Bite	Fracture	Burn (Chem, Liquid, Electrical)
Cut/Puncture	Hernia/ Rupture	Amputation	Exposure (Blood/ Body Fluid)
Abrasion/Scratches	Heart Attack/Stroke	Sprain/Strain	Skin Irritation/ Dermatitis
Bruise/Contusion/Crushing	Hearing Impairment	Death	Other
Concussion/ Loss of	Exposure (Chem. Temp. Elect)		

Injury Cause (Circle)

Struck by/ Against Object	Caught in/Under/ Between	Jumping or Climbing	Animal, Insect, Human
Fall-Same Level, Different Level	Pushing/Pulling/ Lifting/ Carrying	Noise	Repetitive Motion/Trauma
Hot Object, Substance or Fire	Vehicle Accident/ Struck by Vehicle	Slipping/Tripping	Other

Was injury caused by another person, faulty/broken equipment, a vehicle?	Yes	No	

If yes, explain:

Body Part Injured (Circle)

Head/Neck/Face/Mouth	Wrist L / R	Hips/ Buttocks	Arm L / R	Elbow L / R
Eye L / R	Hand L / R	Fingers L / R Digit:	Pelvis/ Groin	Shoulder L / R
Ear L / R	Back (Upper Lower)	Knee L / R	Ankle L / R	Foot L / R
Leg (Thigh Calf)	Toes L / R Digit:	Respiratory	Other	No Physical Injury

Chest/Abdomen Including internal organs

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/ Hosp Name, Address, and telephone number:

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 and have witness complete attached form

Name	**Address**	**Phone**	**Date**

Supervisor's Signature:	**Date:**