Southeast HEALTH

EMPLOYEE'S REPORT OF INJURY

TO BE COMPLETED BY **EMPLOYEE**

- ✓ Please **complete entire form** and send all copies **with the injured employee** to the **Employee Health Department.**
- ✓ Employees **requiring emergency treatment** after hours should **report to the Emergency Department.**
- ✓ All copies of this form shall be collected in the Emergency Department, if treated there, and forwarded to Employee Health.
- ✓ Employees who receive treatment in the Emergency Department shall follow up with the Employee Health Department the next business day.

EMPLOYEE NAME	EMP. HOME ADDRESS			
DATE OF BIRTH	SOCIAL SECURITY NO.	SEX ☐ M ☐ F	MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Divorced	NO. OF DEPENDENTS
EMPLOYEE'S DEPARTMENT	JOB TITLE	HIRE DATE	HOME PHONE NO.	
INCIDENT DATE	INCIDENT TIME ☐ AM ☐ PM	LOCATION OF INCIDENT		
DATE REPORTED	TIME REPORTED	DATE AND HOUR LAST WORKED		

TYPE OF INCIDENT ☐ MUSCLE STRAIN ☐ BLOOD & BODY FLUID EXPOSURE ☐ BRUISE ☐ FALL ☐ OTHER_____
☐ LACERATION ☐ NEEDLESTICK

Where you on the Southeast Health premises at the time of the injury? ☐ YES ☐ NO
Have you ever had any other condition or injury involving this part of your body? ☐ YES ☐ NO
Have you claimed or received settlement for this injury before? ☐ YES ☐ NO

DESCRIBE FULLY WHAT YOU WERE DOING AND HOW THE INJURY OCCURRED. GIVE NATURE AND LOCATION OF INJURY.
Example: Give part of body, right or left, etc. (Use attachments if necessary)

WITNESSES	PHONE	PERSON/PERSONS TO WHOM INJURY WAS REPORTED

I HEREBY STATE THIS INFORMATION TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I understand that a drug/alcohol screen/test will be performed following all work-related injuries. If I refuse to be tested, I understand that Workers Compensation benefits may be denied, and that I may receive disciplinary action (including dismissal) for such refusal.

EMPLOYEE SIGNATURE: DATE:

ACCIDENT INVESTIGATION SECTION (To be completed by Manager or Supervisor)

From your investigation, what caused the accident? Describe in detail what happened. Example: Object/Equipment/Substance (Use attachments, if necessary)

Corrective Action: What action has or will be taken to prevent recurrence? (Use attachments if necessary.)

MANAGER/SUPERVISOR SIGNATURE: DATE: