**Workers Compensation Report Form**

**Employee Information  
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_  
Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Supervisor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Incident Details**

| **Date of Incident** | **Time of Incident** | **Location** | **Injury Type** |
| --- | --- | --- | --- |
| **//\_\_\_\_\_\_** | **\_\_\_\_ : \_\_\_\_ AM/PM** |  |  |

**Injury Description  
☐ Head  
☐ Neck  
☐ Back  
☐ Arm/Hand  
☐ Leg/Foot  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Was Safety Equipment Used? ☐ Yes ☐ No  
If no, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Details  
Treatment Required: ☐ Yes ☐ No  
Medical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Follow-up Care Needed? ☐ Yes ☐ No**

**Witness Information  
Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Certification  
I certify that the above information is accurate to the best of my knowledge.**

**Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_  
Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**