**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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**