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: ____ / ____ / _____