Employee's First Report of Injury

WC Employee's First Report of Injury Form

*To be completed by accident witness ONLY

Date of Incident: _____ Time of Incident: _____

Employee's Name: _____

Male ☐ Female ☐ Date of Birth: _____ SSN#: _____

Home Address: _____

City: _____ State:_____ Zip:_____ Phone:_____

Position Title: _____ How long employed here: _____

Weekly Salary: _____

Location of Accident (address): _____

Area (loading dock, bathroom): _____

Describe fully how the accident occurred (including events that occurred immediately before the incident):

_____

_____

_____

Describe bodily injury sustained (be specific about body parts(s) affected):

_____

_____

_____

Recommendation on how to prevent this accident from recurring: _____

_____

Name of Supervisor: _____ Phone: _____

Name(s) of Witness(es): _____ Phone: _____

Name(s) of Witness(es): _____ Phone: _____

When did you report accident to your supervisor? _____

To whom did you report the injury? _____

Do you require medical attention? ☐ Yes ☐ No ☐ Maybe

Signature of Employee: _____ Date: _____