



WORK-RELATED INJURY AND INCIDENT REPORT FORM

DATE: _____

EMPLOYEE INFORMATION

Name

Home Address

Phone Number E-Mail

Date of Birth
(MM/DD/YYYY)

INCIDENT AND/OR INJURY

Date of Incident or Injury (MM/DD/YYYY) Time of Incident or Injury

Time You Began Work

Where did the incident or injury happen?

(Example: while driving eastbound on 164 in [city] in route to customer, while parking at customers home located at [address], while at customers home located at [address], etc.)

What were you doing before the incident occurred? Describe the activity, as well as the tools, equipment, or material you were using. Be specific.

(Example: stepping into the van while carrying a tub of water for grey water disposal, etc.)

How did the incident or injury occur? Describe what happened.

(Example: Moving in the vehicle while bathing customers pet and slipped and fell; developed soreness in my wrist over time, etc.)

What was the injury or illness? Tell us the part of the body that was affected and how it was affected. If this questions does not apply, leave it blank.

(Example: strained back; fracture; carpal tunnel syndrome; etc.)

What object or substance directly harmed you? If this questions does not apply, leave it blank.

(Example: "concrete road", "scissors", "customers pet".)

TREATMENT INFORMATION

Did you receive medical treatment? Yes No

If yes, where was treatment given? Be specific (Example: in ambulance at customers home, at Norfolk General Hospital, etc.)

Name of treating physician or health care professional

Were you treated in an emergency room? Yes No

Were you hospitalized overnight (in-patient)? Yes No

Signature: _____