# Employee Report of Injury

Name:_____ DOB: _____

Home Address:_____

Phone Number:_____ Employee ID#:_____

Job Title: _____Work Site: _____

Where did incident occur: _____ Work Schedule: _____
*(Hours from when to when: 6:00am-3:00pm)*

Date of Accident:_____ Time of Accident:_____

Describe what you were doing when the injury occurred *(specify any tools, chemicals, equipment being used):*

_____

_____

Describe where the accident happened *(sidewalk, classroom, playground)*:_____

_____

Describe how the accident occurred:_____

_____

_____

Describe injury *(specific body parts affected)*: _____

_____

List any witnesses or other persons involved:_____

Employee's Signature_____Date:_____

**RETURN COMPLETED FORM TO HEALTH BENEFITS**