

EMPLOYEE INJURY REPORT

(To be filled out and faxed to Central Office immediately)

2601 Bemiss Road, Suites J - M, Valdosta, GA 31602

Name _____ Social Security # _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Sex: Male _____ Female _____ Date of Birth _____ - _____ - _____ Age _____ Telephone _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Place of accident (with address) _____

County _____ Date of Occurrence _____ - _____ - _____ Time of Day _____ a.m. _____ p.m.

Time work day began on date of injury _____ Date employer made aware of injury _____

Who was present at time of injury/accident?

Name _____

Address _____

Name _____

Address _____

Describe injury: _____

Describe in details what happen prior, during and after the injury: _____

Describe what unsafe condition(s) or act(s) directly caused this accident: _____

Indicate the part of body affected _____

Name and Address of Treating Practitioner _____

Name and address of hospital, if hospitalized _____

Did employee work the day following the injury? Yes No

First date employee failed to work a full day _____

If employee left work on day of accident, state exact time _____ a.m. _____ p.m.

Employee Signature

Date

Use reverse for additional information

Employee Injury Report (Cont'd)

FOR SUPERVISOR

Name of Supervisor /Next in Charge completing: _____ DATE _____

Describe **EXACTLY** what happened: _____

Was injury caused by employee negligence or violation of rules? Yes No

Could this injury have been prevented? Yes No

Was injured worker secluded alone in assigned work area, or working in area with Alone With Others
other workers?

Are there recommendations of disciplinary action or corrective measures? Yes No

CAUSES: What have **YOU** identified as the "Causes" of this Incident/ Accident- List Below:

Corrective Actions- What Corrective Actions do **YOU** recommend be implemented to prevent a recurrence of this Incident/Accident:

COMMENTS: _____

Signature of Supervisor

Date

Signature of Benefit Specialist

Date

Signature of Personnel Director

Date