

REPORT OF INJURY-EMPLOYEES

\_\_\_\_\_  
Name of Injured (Print Name)

\_\_\_\_\_  
Address of Injured Telephone Number

\_\_\_\_\_  
Time of Injury Date of Injury

\_\_\_\_\_  
Exact Location

\_\_\_\_\_  
Accident Observed By Position

\_\_\_\_\_  
Accident Reported By Position

\_\_\_\_\_  
Doctor Notified (Name) Time

\_\_\_\_\_  
Ambulance Notified (Name) Time

\_\_\_\_\_  
Hospital Taken To By Whom

\_\_\_\_\_  
Doctor Taken To By Whom

\_\_\_\_\_  
Person Completing this Report Signature Title

Describe Nature of Injury and Cause in Detail: (Please Print or Type)

1.

2.

3.

4.

(Use reverse side if necessary)

\_\_\_\_\_  
Supervisor's Signature Date & Time

**IMPORTANT** One (1) copy to be delivered promptly to the Superintendent  
One (1) copy to be retained by the Supervisor

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Time and date received in Superintendent's office.