

1	Complete an Employee Injury Report for each employee injured.		
2	Agency name	Today's date	
3	Date of incident (mm/dd/yyyy)	Time of incident (hh/mm a.m./p.m.)	
4	Name of person completing report	Title of person completing report	
5	Business phone	Business email	
6	How did the incident occur? (Provide a one-line factual description.)		
7	Name of the location (park, pool, community center; <i>Ex. Smith Pool, Johnson Community Center</i>) or nearest intersection where the incident occurred.		
8	Is there an address for this location? If yes, please provide the following:		
	Street address		
	City	State	Zip code
9	Location (Specify the exact type of location/facility where injury occurred. <i>Ex. maintenance garage, sports field, aquatic outdoor, golf course, etc.</i>)		
10	Primary location (Specify exact location. <i>Ex. lap pool, cart storage, classroom, pavilion</i>)		
11	Employer's FEIN		
12	Did the employee miss more than three (3) scheduled workdays?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
13	What was the employee doing when the accident occurred?		
14	How did the incident occur? (Provide a detailed factual description.)		
15	Employee last name	First name	
	Address		
	City	State	Zip code
	Home phone #	Work phone #	Cell phone #
	Best number to contact employee		Email
	Social security number	Date of birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
	Marital status (divorced/married/single/unknown)	Number of dependents	Does employee speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Average weekly wage	Job title/occupation	

15	What is the employee's employment status?			
	<input type="checkbox"/> Permanent full-time	<input type="checkbox"/> Permanent part-time	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Intern <input type="checkbox"/> Other
	Date hired (mm/dd/yyyy)	What is the employee's tenure? (length of employment)		
		<input type="checkbox"/> Less than 1 yr. <input type="checkbox"/> 1-3 yrs. <input type="checkbox"/> 4-10 yrs. <input type="checkbox"/> 11-19 yrs. <input type="checkbox"/> More than 20 yrs.		
	Time employee began work on day of incident (hh/mm a.m./p.m.)			
	Last date employee worked prior to date of incident (mm/dd/yyyy)			
	If the employee died as a result of the accident, give the date of death. (mm/dd/yyyy)			
	Did the incident occur on agency premises? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
	Injury or illness? <input type="checkbox"/> Injury <input type="checkbox"/> Illness			
	Describe the injury or illness (affected body part and type of injury; <i>Ex. contusion, bruise, laceration, sprain, break, etc.</i>)			
What object or substance, if any, directly harmed the employee?				
16	Did the injured employee seek medical attention?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
17	If yes, was the treatment given away from the worksite?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
18	Was the employee treated in an emergency room?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19	Was the employee hospitalized overnight as an inpatient?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
20	Name of treating physician, health care provider, or emergency room			
	Address			
	City	State	Zip code	Phone number