

# EMPLOYEE INJURY REPORT

This form applies to all job-related injuries happening to any employee while on the job.

COMPANY NAME:

DATE:

ADDRESS:

YOUR NAME (filling out this form):

POSITION:

PHONE:

## INJURY INFORMATION

DATE OF INJURY:

DESCRIPTION OF INJURY AND HOW IT OCCURRED:

NAME OF WITNESS:

## INJURED EMPLOYEE

NAME:

SOCIAL SECURITY #:

ADDRESS:

D/O/B:

DATE HIRED:

STATE OF HIRE:

HOME PHONE:

JOB TITLE:

TIME EMPLOYEE BEGAN WORK:

TIME OF INJURY:

P/T or FULL

WAGE:

TREATMENT PROVIDED TO DATE:

WHERE WAS TREATMENT GIVEN (NAME, ADDRESS, PHONE):

WILL EMPLOYEE NEED TO MISS WORK AS A RESULT OF THIS INJURY?

PLEASE FAX THIS FORM AND ANY MEDICAL BILLS CREATED AS A RESULT OF THIS INJURY TO YOUR SUPERVISOR AND TO CONLON COMPANY (843) 883-5299.

THANK YOU.