

SAMPLE PERSONAL INJURY REPORT

INSTRUCTIONS: This form must be filled out and signed by each employee injured on duty, and by each employee having knowledge or information concerning such an incident.

NAME OF INJURED PERSON		SENIORITY DATE	<input type="checkbox"/> EMPLOYEE	<input type="checkbox"/> OTHER
ADDRESS OF INJURED PERSON (STREET, CITY, ZIP CODE)			<input type="checkbox"/> MARRIED	<input type="checkbox"/> SINGLE
EMPLOYEE INSURANCE COVERAGE <input type="checkbox"/> Travelers Ins. <input type="checkbox"/> Hospital Services Assoc. <input type="checkbox"/> Travelers Managed Care System				
LOCATION OF INCIDENT	DATE OF INCIDENT	TIME	<input type="checkbox"/> DAYLIGHT	<input type="checkbox"/> DARK
DESCRIBE WEATHER <input type="checkbox"/> CLEAR <input type="checkbox"/> DRY <input type="checkbox"/> RAIN <input type="checkbox"/> SNOW <input type="checkbox"/> FOG		IF THIS REPORT IS BEING MADE BY OTHER THAN THE INJURED PERSON, DID YOU SEE THE INCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DESCRIBE FULLY HOW INCIDENT OCCURRED: <hr/> <hr/> <hr/> <hr/>				
DESCRIBE INJURIES: <hr/>				
IF INJURY REQUIRED SERVICES OF A PHYSICIAN, INDICATE TYPE S OF SERVICE REQUIRED: <input type="checkbox"/> Stitches <input type="checkbox"/> Prescription <input type="checkbox"/> First Aid Only <input type="checkbox"/> Other (explain)				
IF DOCTOR CALLED GIVE NAME:		ADDRESS:		
IF INCIDENT OCCURRED WHILE WORKING WITH CARS OR ENGINES, LIST INITIALS AND NUMBERS: <hr/>				
DEFECTS INVOLVED: <input type="checkbox"/> NONE <input type="checkbox"/> MACHINERY <input type="checkbox"/> TOOLS <input type="checkbox"/> STRUCTURES <input type="checkbox"/> EQUIPMENT <input type="checkbox"/> OTHER DEFECTS				
IF ANY DEFECTS INVOLVED IDENTIFY AND DESCRIBE: <hr/>				

IMPORTANT: List All Persons Who Witnessed the Incident or Can Give Any Information About It:

NAME	OCCUPATION	ADDRESS (Show Street and City)

THE ABOVE IS A CORRECT STATEMENT

SIGNED _____ DATE _____ 20____ AGE _____

ADDRESS _____ PHONE _____

OCCUPATION _____ SOCIAL SECURITY No. _____ EMPLOYEE No. _____

ANSWER ALL QUESTIONS FULLY (Use Reverse Side If Necessary)