EMPLOYEE'S REPORT OF INJURY

To be completed and signed by injured workers.

(Instructions: Fax to HR 310-667-9128 on day of injury or day injury first reported)

Full Employee Name: Last, First, M.I.	Social Security Number: - -	Home Phone Number or Cell: ( ) -
Home Address: Street: Unit: City: State: Zip:	Date of Birth: Sex: ___ Male, ___ Female Married: ____ Yes, ____ No Number of Dependants: ____ Your job title: _____	

At this time are you in need of medical attention? _____ Yes, _____ No

Date of next medical appointment, if any:

Did the doctor place you on restricted work duties? ____ Yes, _____No

Did the doctor place you off work? _____ Yes, _____ No

Are you please with the medical treatment you received? ____ Yes, _____ No. If no, please explain.

Date the injury occurred: Time the injury occurred: Time of day you started to work:	To whom did you first report the injury? Name any witnesses to the injury:

What were you doing at the time the injury occurred? Example: Cutting open a cardboard box.

What equipment or material actually caused the injury? Example: cutting blade, grinder, forklift, floor.

How did the accident occur? Example: When cutting open the box the blade slipped and struck my finger.

List the body part(s) affected by the injury and the type of injury: Example: Right finger laceration.

SIGN NAME: DATE:

BELOW TO BE COMPLETED BY HR

Case Number From OSHA Log 300:	Date Injury Reported To Management: If Restrictions, Date Started: If Lost Work Days, First Lost Work Day: Date Employee Returned To Work:
Name of Doctor / Facility: Address:	

Revised 1/2011 USE BACK SIDE IF MORE SPACE IS NEEDED.