

WORK INJURY REPORT

WORK INJURY REPORT

Reported By:		Incident Date:															
Job Title:		Incident Time: AM/PM															
INJURY INFORMATION																	
Injured Person Name:		Job Title:															
Incident Location:																	
Injury Type																	
<table border="0"><tr><td><input type="checkbox"/> Cut</td><td><input type="checkbox"/> Inflammation/Swelling</td></tr><tr><td><input type="checkbox"/> Bruising/Contusion</td><td><input type="checkbox"/> Electric Shock</td></tr><tr><td><input type="checkbox"/> Abrasion</td><td><input type="checkbox"/> Poisoning</td></tr><tr><td><input type="checkbox"/> Fracture/Dislocation</td><td><input type="checkbox"/> Insect Bite</td></tr><tr><td><input type="checkbox"/> Amputation</td><td><input type="checkbox"/> Loss of Consciousness</td></tr><tr><td><input type="checkbox"/> Sprain/Strain</td><td><input type="checkbox"/> Physical Altercation</td></tr><tr><td><input type="checkbox"/> Burn</td><td><input type="checkbox"/> Illness</td></tr><tr><td><input type="checkbox"/> Blisters</td><td><input type="checkbox"/> Other _____</td></tr></table>				<input type="checkbox"/> Cut	<input type="checkbox"/> Inflammation/Swelling	<input type="checkbox"/> Bruising/Contusion	<input type="checkbox"/> Electric Shock	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Fracture/Dislocation	<input type="checkbox"/> Insect Bite	<input type="checkbox"/> Amputation	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Physical Altercation	<input type="checkbox"/> Burn	<input type="checkbox"/> Illness
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<input type="checkbox"/> Amputation	<input type="checkbox"/> Loss of Consciousness																
<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Physical Altercation																
<input type="checkbox"/> Burn	<input type="checkbox"/> Illness																
<input type="checkbox"/> Blisters	<input type="checkbox"/> Other _____																
Injured Body Part																	
Injury Details (Cause and Description)																	
<hr/> <hr/> <hr/> <hr/>																	
Does the employee comply to the Safety policy at the time the incident occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No																	

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Isaac Grant Thompson



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