

Injury Report

Name: _____ Date: _____
Employee ID: _____ Title: _____
Sex: _____ DOB: _____
Email Address: _____ Phone: _____
Address: _____

Incident

Date of Accident: _____ Time of Accident: _____
Reported to: _____ Reported by: _____
How did the injury occur? _____

Witnesses: _____

Others Involved: _____

Caused by: ☐ Equipment Malfunction ☐ Safety Violation ☐ Collision ☐ Fall/Falling Object
Other: _____

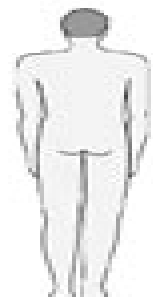
Injury

Description of Injury: _____
Nature of Injury: ☐ Burn ☐ Cut ☐ Bruise ☐ Scrape ☐ Break ☐ Sprain ☐ Strain ☐ Concussion
Other: _____

Part(s) of Body Affected

☐ Left ☐ Right

<input type="checkbox"/> Foot	<input type="checkbox"/> Ankle	<input type="checkbox"/> Knee	<input type="checkbox"/> Shin
<input type="checkbox"/> Calf	<input type="checkbox"/> Thigh	<input type="checkbox"/> Buttocks	<input type="checkbox"/> Waist
<input type="checkbox"/> Hip	<input type="checkbox"/> Groin	<input type="checkbox"/> Stomach	<input type="checkbox"/> Ribs
<input type="checkbox"/> Chest	<input type="checkbox"/> Back	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Neck
<input type="checkbox"/> Hand	<input type="checkbox"/> Wrist	<input type="checkbox"/> Forearm	<input type="checkbox"/> Elbow
<input type="checkbox"/> Bicep	<input type="checkbox"/> Head	<input type="checkbox"/> Forehead	<input type="checkbox"/> Ears
<input type="checkbox"/> Eyes	<input type="checkbox"/> Nose	<input type="checkbox"/> Mouth	<input type="checkbox"/> Chin



Care

Doctor: _____ Hospital: _____
Insurance: _____ Account No: _____
Care Provided: _____

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Aspen Reference Group,Antosz



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