Workplace Injury Form

Section 1: Employee Information

Name: _____
Job Title: _____
Department: _____
Employee ID (if applicable): _____
Supervisor's Name: _____
Contact Information: _____

Section 2: Incident Details

Date of Incident: _____
Time of Incident: _____
Location of Incident: _____
Description of Incident: (Describe what happened, including how the injury occurred, any equipment involved, etc.)

Section 3: Injury Details

Type of Injury: (e.g., cut, sprain, burn, etc.) _____
Body Part(s) Affected: _____
Was First Aid Administered? (Yes/No): _____

- If Yes, by whom? _____

Did the Employee Seek Medical Attention? (Yes/No): _____

- If Yes, provide details (e.g., clinic/hospital name): _____

Section 4: Witness Information

Were there any witnesses to the incident? (Yes/No): _____

- If Yes, provide witness details:
    - Name: _____
    - Contact Information: _____
    - Statement: _____

Section 5: Employer Review

Workplace Injury Form

Date Reported to Employer: _____
Name of Person Receiving Report: _____
Was the Area Secured After the Incident? (Yes/No): _____
Actions Taken Following Incident:

Management comments:

Section 6: Employee Acknowledgment I certify that the above information is accurate to the best of my knowledge.

Employee Signature: _____ Date: _____

Section 7: Employer Acknowledgment I have reviewed this report and will ensure appropriate follow-up actions are taken.

Employer/Supervisor Signature: _____ Date:_____