UNIFIED STAFFING, INC.

REPORT OF INJURY OR ILLNESS

Location	State	Dept	Phone				
Employee Name	DOB	Employee #					
Address	City	State	Zip				
SS#	Married	☐ Yes	☐ No	Sex	☐ Male	☐ Female	
Job Title	Hire Date						

Description of Incident:

Release of Medical Information: *I certify that the above information is true to the best of my knowledge and I authorize the release to my employer and workers' compensation company all records relevant to my disability and my claim for disability or workers' compensation benefits, including but not limited to medical diagnosis, prognosis, treatment, and periods of hospitalization. It is understood that the company will use the information to verify my disability and determine my eligibility of appropriate benefits. This authorization applies to physicians and other health care providers, hospitals, clinics, insurance companies, workers' compensation carriers, and organizations administering benefit programs. This authorization will remain in effect throughout my claim for workers' compensation benefits. A photocopy of this authorization will be as valid as the original.*

Employee Signature:	**Date:**

Incident Details

Date of Incident	Time of Incident	☐ AM	☐ PM	Date Reported		
Incident Location (area)	On Employer Premise	☐ Yes	☐ No			
Witness(es)						
Employee lost time to injury	☐ Yes	☐ No	First Aid Given	☐ Yes	☐ No	
Date Worker Left Work	Time Worker Left Work	Date Worker Returned				
Medical Facility	Doctor					
Follow Up Appointment Scheduled	☐ Yes	☐ No				
Time Off Authorized by Physician	☐ Yes	☐ No	If Yes, How Many Days			
Treatment Given	☐ Prescription	☐ Irrigation	☐ Sutures	☐ Tetanus Shot		
	☐ Brace	☐ Cast	☐ Remove Foreign	☐ None		
☐ Ace Bandage	☐ Other:					

Part of Body Injured

☐ Head		☐ Arm	R L	☐ Trunk	R L	☐ Hip	R L	☐ Foot	R L
☐ Face		☐ Elbow	R L	☐ Shoulder	R L	☐ Thigh	R L	☐ Toe	R L
☐ Eye	R L	☐ Forearm	R L	☐ Chest	R L	☐ Knee	R L	☐ Ribs	R L
☐ Nose		☐ Hand	R L	☐ Back	R L	☐ Leg	R L	☐ Skin	R L
☐ Neck		☐ Finger	R L	☐ Abdomen	R L	☐ Ankle	R L	☐ Other	R L
Other:									

Nature of Injury (mark all that apply)				
☐ Abrasion	☐ Puncture	☐ Chemical	☐ Inhalation	☐ Burn
☐ Bruise-Crushed	☐ Fracture	☐ Hearing	☐ Fatality	☐ Other
☐ Laceration	☐ Poisoning	☐ Sprain	☐ Heat/Cold	☐
☐ Amputation	☐ Dermatitis	☐ Strain	☐ Foreign Object	☐
Other:				

Investigation Supervisor			
Date of Investigation		Investigator Name	
Employee's Supervisor		Supervisor's Phone	
Who was immediately in charge at time of injury?			
Employee task trained?	☐ Yes ☐ No	Yes, explain:	
Equipment Involved	Type	Model	Mfg.

Cause of Injury – (mark all that apply)				
☐ Body Motions	☐ Hot/Cold	☐ Flame/Smoke	☐ Ladders	☐ Slip/Trip/Fall
☐ Bldg/Structure	☐ Conveyors	☐ Furniture	☐ Machines	☐ Flying Object
☐ Chemicals	☐ Electrical –HV	☐ Hand Tool	☐ Notices	☐ Flash
☐ Vehicles	☐ Electrical - LV	☐ Hoisting	☐ Particles	☐ Other
☐ Falling Objects				
Other:				

Cause of Incident – (mark all that apply)				
☐ Equipment	☐ Material Handling	☐ Excessive Speed	☐ Poor Housekeeping Housekeeping	☐ Horseplay
☐ Lack of Attention	☐ Slippery Surface	☐ Procedure Failure	☐ Fatigue	☐ Other
Other:				

Analysis
Description of Incident:

Steps Taken to Prevent Similar Occurrence	
☐ Reinstruction of Employee	☐ Formal Disciplinary Action
☐ Reminder Instruction to All Employees	☐ Installation of Guard Device
☐ Personal Protective Equipment Required	☐ Counseling of Employee
Explain:	

Supervisor Signature:	**Date:**

Send report to: Unified Staffing · Phone (810) 407-6713 · Fax (810) 407-6795

UNIFIED STAFFING, INC.

SUPERVISOR ACCIDENT REPORT

Injured Employee's Name:
Date and Time of Incident:
Date and Time Reported:
Home Phone:
Witness Names:
Cause of Accident:
Was a Safety Procedure Violated? Describe:
Accident Site Inspection and Comments:
Recommendations and Comments:
Is there a potential outside liable party responsible for the cause of this incident?

Description of Incident (Use additional sheets of paper, if more space is needed)	
Supervisor Signature:	Date:

UNIFIED STAFFING, INC.

INJURY/ACCIDENT WITNESS STATEMENT

Witness Name:			Date:
Department:			
Home Address:	City:	State:	Zip:
Home Phone:			

Accident Details

Name of Injured Employee:			
Date of Accident:	Approximate Time of Accident:		
Does the witness know the injured party?		☐ Yes	☐ No

Witness Statement

How did the accident occur? What did the witness observe? What did they do?
(Use additional sheets of paper, if more space is needed)

Witness Signature:	Date: