WYC Employee Injury Report Form

EMPLOYEE INFORMATION

Name: _____ Position: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

ACCIDENT INFORMATION

Injury date: _____ Time: _____ Location: _____

Witness one: _____ Phone: _____

Witness one: _____ Phone: _____

Describe what happened in detail including individuals and equipment involved:	
Describe all injuries in detail including any part of the body effected:	
Describe any first aid treatment given:	
Name & address of physician:	**If applicable, name & address of hospital:**
Comments from witness:	**Other comments:**

Did the employee miss work? ☐ Yes ☐ No If yes, when was the last day and time at work?

Did the employee return to work? ☐ Yes ☐ No If yes, date and time employee returned to work?

_____ _____

Employee Signature Date Supervisor Signature Date

White Copy: Administrative Office Yellow Copy: Employee