EMPLOYEE'S WORK INJURY / INCIDENT REPORT

Complete and fax to Jacque the SAME day of the injury – 773-326-1660

Name _____ Social Security Number _____

Address _____ Birth Date: _____

City/ State/Zip _____ Phone: _____

Service Center GR- _____

Job Title _____ Date hired _____ Pay Rate: _____

ACCIDENT / INCIDENT DATE AND TIME

Date of Injury/Incident _____ Time of accident/incident _____

Date accident /incident was reported _____

PART OF BODY AFFECTED BY INJURY (check all that apply)

Hand:
- ☐ Finger: Left/Right/ Both
  Which finger/s _____
- ☐ Wrist Left/ Right/ Both
- ☐ Top of hand Left/ Right/ Both
- ☐ Palm: Left/ Right/ Both

Foot:
- ☐ Toe: Left/Right/ Both
  Which toe/s _____
- ☐ Heal: Left/Right/ Both
- ☐ Sole: Left/Right/ Both
- ☐ Ankle: Left/Right/ Both

Torso:
- ☐ Lower back
- ☐ Upper back
- ☐ Abdomen
- ☐ Chest

Arm:
- ☐ Shoulder: Left/ Right/ Both
- ☐ Elbow: Left/ Right/ Both
- ☐ Upper arm: Left/ Right/ Both
- ☐ Lower arm: Left/ Right/ Both
- ☐ Wrist: Left/ Right/ Both
- ☐ **OTHER**: Be as specific as possible:

Leg:
- ☐ Thigh: Left/Right/ Both
- ☐ Calf/ shin: Left/Right/ Both
- ☐ Knee: Left/Right/ Both

Head:
- ☐ Eye Circle: Left/ right/ both
- ☐ Ear Circle: Left/ right/ both
- ☐ Nose
- ☐ Neck
- ☐ Other _____

TYPE OF INJURY

- ☐ Absorption
- ☐ Amputation
- ☐ Bruise
- ☐ Burn
- ☐ Concussion
- ☐ Foreign body in eye
- ☐ Other _____
- ☐ Fracture
- ☐ Inflammation
- ☐ Ingestion
- ☐ Inhalation
- ☐ Irritation
- ☐ Laceration (cut)
- ☐ Over-exertion
- ☐ Over-exposure (heat/cold)
- ☐ Puncture
- ☐ Strain
- ☐ Sprain
- ☐ Physical Attack (Bite, Kick, Pinch, Scratch, Hit)

Have you ever had a similar injury? ☐ Yes - Please explain _____
☐ No

ACCIDENT INFORMATION

Where did accident occur? _____

_____

What were you doing when the accident/incident occurred? _____

_____

_____

List any tool, machine, equipment or chemical involved. _____

_____

What caused the accident/incident? _____

_____

_____

How could this accident/incident be prevented? _____

_____

_____

Describe any unsafe conditions you experienced when the accident/incident occurred. _____

_____

_____

List the names and phone numbers of anyone who witnessed your accident/incident. _____

_____

Did you seek medical treatment? ☐ No ☐ Yes - If yes, indicate where you received treatment.

_____

_____

By signing below you are indicating this information is true to the best of your knowledge. Providing false information may result in disciplinary action up to and including termination.

_____

Employee Signature

FAX COMPLETED FORM TO 773-326-1660 the same day as injury