Employer's Report of Occupational Injury or Illness

Is this an FYI incident? (Circle One) Yes or No	Complete this form in its entirety for all employee related injuries/illnesses and fax to the office. Notifiy your AC immediately.

Employee Information

First Name:	Last Name:	MI:
SSN:	Date of Birth:	Gender:
Primary Language:	Marital Status:	# of Dependents:
Mailing address:		

City:	State:	Zip:	Phone:

Date of Hire:	Job Title:	Supervisor's Name:

Injury Information

Date of injury:	Time of Injury:	Restaurant #:
Describe the specific Injury or Illness:		
Part of the body affected:	Where did Injury occur:	
Equipment/Materials/Chemicals being used when injury occurred:		
Specific activity being performed:		
Name of person reported to:	Name of any witnesses:	
Injury due to failue of machine, product, or person other than injured? YES or NO	Injury occurred on employer's premises? YES or NO	Other workers injured in event? YES or NO
Do you question that this is a work related injury? YES or NO	If YES, why?	

Treatment Information

Employee sent to a Physician/Clinic/Hospital? YES or NO	Name of facility employee treated at:

Address:	Phone:

City:	State:	Zip:

Work Status

Date Last Worked:	Injured employee missed at least one full day of work? YES or NO	Paid in full for date of injury? YES or NO
Date returned to work:	Still off work: YES or NO	Full Time or Part Time (circle one)
Average hours worked per week:	Days per week:	Does the employee have another job? YES or NO

Verification

Injured Employee's Signature:	Printed Name:	Date:
Form completed by:	Signature:	Date:

Manager Response

Were safety processes followed & used? YES or NO	Was a Safety Consultation Form issued? YES or NO
Was equipment defective? YES or NO	If YES, how?
How could the employee have prevented this from happening?	
How could the employer have prevented this from happening?	