

# Employee Injury Report

## Employee Name & Dates

Name, print _____					
first	initial	last			
Incident date	Time of incident <input type="checkbox"/> AM <input type="checkbox"/> PM	Date reported	Time reported <input type="checkbox"/> AM <input type="checkbox"/> PM	Reported to whom	Began work <input type="checkbox"/> AM <input type="checkbox"/> PM

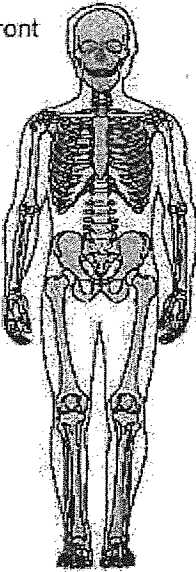
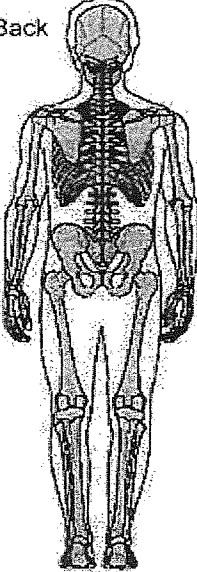




## Medical Treatment

What treatment has the injury required ? <input type="checkbox"/> <b>Off-site</b> (clinic, etc) <input type="checkbox"/> <b>On-site</b> (first aid)	Complete all sections of this injury report <input type="checkbox"/> <b>No Medical Care Provided</b> Complete all sections of this injury report except 1 & 2
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## 1. Employee Information Medical Treatment Only

Home address _____		Work location _____			
City, State, ZIP _____		Work address _____			
Home phone ( ) _____		City, State, ZIP _____			
Cell phone ( ) _____		Work Phone ( ) _____			
Date of hire	Job title	Shift	Supervisor	Union	
Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Dependents (number)	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widow	Language (best)	Social Security - -

## 2. Injury Medical Treatment Only

Front	Back	Describe the injury
		<hr/> <hr/> <hr/>
		What caused the injury (chain, conveyor, tray, etc) <hr/>
		Have you been treated for a work-related injury within the last year ? If YES, explain _____ <hr/> <hr/> <hr/>
		<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">  Left hand           </div> <div style="text-align: center;">  Right hand           </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 20px;"> <div style="text-align: center;">  Left foot           </div> <div style="text-align: center;">  Right foot           </div> </div>



# Supervisor's Accident Addendum

(Personal Injury or Vehicle)

Site Code: \_\_\_\_\_ Dept. Code: \_\_\_\_\_ NCCI Code: \_\_\_\_\_

## Employee Information

Name, print	<small>first</small>	<small>middle initial</small>	<small>last</small>	Incident date	<input type="checkbox"/> Injury					
					<input type="checkbox"/> Vehicle Accident					
Usual occupation	Occupation at time of incident		Wage rate	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Other						
				per	Commission <input type="checkbox"/> Yes <input type="checkbox"/> No					
Hours per day		Date reported	Time	Reported to whom	Photos					
Sun	Mon	Tue	Wed	Thu	Fri	Sat		<input type="checkbox"/> AM <input type="checkbox"/> PM		<input type="checkbox"/> Yes <input type="checkbox"/> No
Agree with employee statement <input type="checkbox"/> Yes <input type="checkbox"/> No (note why)										

## Medical treatment

<input type="checkbox"/> On-site only	<input type="checkbox"/> Off-site treatment	Transportation to medical facility	Date of initial treatment
<input type="checkbox"/> None	<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital	<input type="checkbox"/> Ambulance <input type="checkbox"/> Employee drove self	
<input type="checkbox"/> First aid	<input type="checkbox"/> Emergency room	<input type="checkbox"/> Driven by: _____	
Name of facility	Phone (    )		
Address	City, state, ZIP		

## What Happened

1	How did you become aware of the accident			
Employee stated that:				
2 Employee's Statement				
3 Immediate Control				

## Signatures

Supervisor (print)	Signature	Date
Field Safety Mgr. (print)	Signature	Date



# Confidential Physician's Report

## facility information

Facility Name _____	Address _____
Facility Phone (____) _____	City, State, ZIP _____

This certifies that \_\_\_\_\_ has been under my care  
employee name

## Medical facility information

Facility Name _____	Address _____
	City, State, ZIP _____

Primary Diagnosis

Estimated length of disability  
From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

Date first consulted for this condition \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of visit  
 AM  
 PM

## Return to work status

Regular duty, no further treatment and no restrictions

Estimated time lost  
First Day \_\_\_\_/\_\_\_\_/\_\_\_\_ Date to return to work \_\_\_\_/\_\_\_\_/\_\_\_\_

Restricted (Light Duty) from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Work restricted to the following:  
\_\_\_\_\_  
\_\_\_\_\_

Estimated return to regular (full) duty \_\_\_\_\_

Special instructions to patient  
\_\_\_\_\_  
\_\_\_\_\_

## Signatures

Physician's name  
(please print) \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

I authorize any physician, hospital or other medical provider to release to the above named IBC facility or its representative, any information regarding my medical history, symptoms, treatment, medication, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have a right to receive a copy of this authorization and copies of my work related medical records. Additionally under the HIPAA rules and regulations the requestor has my specific permission to discuss my medical condition or obtain verbal information regarding my medical condition for the duration of my workers' compensation claim. This authorization is to be valid for the duration of my workers' compensation claim. I understand I may obtain a copy of the records at my request

Employee's signature \_\_\_\_\_ Employee print name \_\_\_\_\_ Social Security \_\_\_\_\_