

## Detailed Occupational Injury/Incident Report

**Please complete this form within 24 hours of any work-related injury or illness.**

### 1. Employee Information

**Full Name:**

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**Employee ID (or last 4 SSN):**

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**Home Address:**

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**Phone Number:**

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**Email Address:**

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**Date of Birth:**

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**Job Title:**

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**Department:**

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### 2. Incident Information

**Date of Injury/Illness:**

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**Time of Injury:**

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**Time Work Began:**

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**Location of Incident:**

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Did incident occur on employer property?  Yes  No

**Describe what you were doing just before the incident:**

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**Describe how the incident occurred (be specific):**

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**Object/substance that directly caused harm:**

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### **3. Injury / Illness Information**

**Body part(s) affected:**

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**Nature of injury (sprain, cut, burn, etc.):**

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**Cause of injury:**

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Was safety equipment used?  Yes  No

**If yes, what type of safety equipment?:**

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Have you had a previous injury to this body part?  Yes  No

**If yes, explain:**

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#### **4. Witnesses**

**Witness Name and Contact Information (1):**

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**Witness Name and Contact Information (2):**

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**Witness Name and Contact Information (3):**

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#### **5. Work Status After Incident**

Did you stop work after the incident?  Yes  No

**Date last worked:**

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Have you returned to work?  Yes  No

**Date returned to work (if applicable):**

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#### **6. Medical Treatment**

Did you receive medical treatment?  Yes  No

**Medical provider name:**

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**Medical facility address:**

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Were you treated in an emergency room?  Yes  No

Were you hospitalized overnight?  Yes  No

## 7. Reporting Information

**Who did you report the injury to?:**

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**Date reported:**

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**Additional comments:**

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## 8. Employee Statement and Acknowledgment

I certify that the information provided above is true and accurate to the best of my knowledge. I understand that providing false or misleading information may result in disciplinary action and may affect my eligibility for workers' compensation benefits. I authorize the City of Ranson and its representatives to use this information for the purpose of processing my injury claim and complying with OSHA and workers' compensation requirements.

**Employee Signature:**

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**Date:**

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