**Occupational Injury/Illness Report**

Instructions:  
The employee completes this form. Please state facts as accurately as possible. Provide this form to your Supervisor.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Employee | | Job Title | | | | | |
| Home Address | | | | | Phone Number | | |
| Date and Time of Incident | | Date, Time & Supervisor Reported to: | | | | | |
| Location of Incident | | City | | | | Building/Room | |
| Describe specifically what you were doing at the time of the incident/accident: | | | | | | | |
| What body part was injured? | | | | | | | |
| Name of witness: | | | | | | | |
| Did this incident cause any property damage? 🞏 Yes 🞏 No If yes, please describe: | | | | | | | |
| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ accept/decline (circle one) to seek medical treatment at this time. Note: I understand should I  Employee Print Name require any medical treatment for this incident in the future, I will advise my Supervisor immediately. | | | | | | | |
| ( Labor Code § 5405 states you have up to 1 year from the date of injury to seek medical treatment) | | | | | | | |
|  |  | |  |  | | |  |
|  | Supervisor signature | |  | Date | | |  |
|  | | |  |  | | |  |
|  | Employee signature | |  | Date | | |  |
|  |  | |  |  | | |  |

Revised: 7/24/19