**Occupational Injury/Illness Report**

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

|  |  |
| --- | --- |
| 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