



Waccamaw Economic Opportunity Council, Inc.



INJURY REPORT FORM

DATE OF INCIDENT: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_ EMPLOYEE DATE OF BIRTH: \_\_\_\_\_

EMPLOYEE ADDRESS: \_\_\_\_\_ EMPLOYEE HOME PHONE: \_\_\_\_\_

\_\_\_\_\_ JOB TITLE: \_\_\_\_\_

EMPLOYEE SOCIAL SECURITY #: \_\_\_\_\_

WORK LOCATION: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

ADDRESS OF PLACE OF INCIDENT: \_\_\_\_\_

TIME WORK DAY BEGAN: \_\_\_\_\_ AM OR PM

TIME AND DATE EMPLOYER NOTIFIED: \_\_\_\_\_

SUPERVISOR NAME NOTIFIED: \_\_\_\_\_

TYPE OF INJURY: (examples: scrape, cut, bruise, break, etc.) \_\_\_\_\_

PART OF BODY AFFECTED: (examples: left foot, right arm, lower right back, etc.) \_\_\_\_\_

ACTIVITY EMPLOYEE WAS ENGAGED IN: (examples: walking, driving, sitting, etc.) \_\_\_\_\_

DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT CAUSED THE EMPLOYEE'S INJURY: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

WHAT SAFEGUARDS OR SAFETY EQUIPMENT WAS OR WAS NOT PROVIDED THAT COULD HAVE PREVENTED THE INJURY: (examples: safety glasses, gloves, seat belt, wet floor signs, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WITNESS NAMES #1 \_\_\_\_\_  
AND PHONE NUMBERS #2 \_\_\_\_\_  
#3 \_\_\_\_\_

I do understand that if medical treatment is required for myself immediately that I am to be taken to the nearest emergency medical facility. If medical treatment is required at a later time, I must receive workers compensation authorization prior to any medical treatment.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SUPERVISOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME OF PERSON COMPLETING THIS FORM: \_\_\_\_\_