EMPLOYEE'S REPORT OF INJURY

(To be completed by the employee only.)

Employee's name: _____ Male___ Female___
Last First Middle

Date of birth: ___/___/____ Home telephone#(_____) _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Present classification: _____ How long employed here: _____

Social Security No.: _____-_____-_____ Weekly salary: _____

Location of accident: _____
Address Area (loading dock, bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident):

_____

_____

_____

_____

Describe bodily injury sustained (be specific about body part(s) affected): _____

_____

_____

Recommendation on how to prevent this accident from recurring: _____

_____

Name of supervisor: _____ Phone# _____
Last First

Name(s) of witness(es): _____ Phone# _____
(Attach witness(es) report(s)

When did you report the accident to your supervisor? _____

To whom did you report the injury? _____

Do you require medical attention? Yes: _____ No: _____ Maybe: _____

Name of your treating physician: _____ Phone# _____

Signature of employee: _____ Date: _____

Department of Administrative Services
Risk Management Services
200 Piedmont Avenue, S.E., Suite 1208 West Tower
Atlanta, Georgia 30334-9010