MARANA AZ
HUMAN RESOURCES

Employee Report of Injury

Employees are to complete this form as soon as possible for all work place injuries/illnesses/or near misses no matter how minor. Once the form is completed forward to your supervisor immediately.

NAME:_____**EMPLOYEE NUMBER:**_____

ADDRESS: _____**PHONE NUMBER:**_____

DATE OF BIRTH:_____ **DATE OF HIRE:**_____**MARITAL STATUS:** _____

JOB TITLE:_____ **DEPARTMENT:**_____ **GENDER:**_____

DATE OF INJURY/ILLNESS:_____**TIME OF EVENT:**_____**DATE SUPERVISOR NOTIFIED:**_____

WORK START TIME:_____ **NORMAL WORK SCHEDULE (DAYS/HOURS):**_____

LAST DAY OF WORK AFTER INJURY:_____ **DATE OF RETURN TO WORK:**_____

DID INJURY OCCUR ON TOWN PREMISES: ☐Yes ☐No **LOCATION OF INCIDENT:**_____

WHAT WAS THE INJURY/ILLNESS: (Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." *Examples:* "strained back"; "chemical burn")

PART OF BODY INJURED:_____ **SIDE INJURED:** ☐Left ☐Right

WHAT HAPPENED (Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time.")

WHAT OBJECT OR SUBSTANCE DIRECTLY CAUSED HARM (*Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.)*

WHAT WERE YOU DOING JUST BEFORE THE INCIDENT OCCURRED (Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry.")

HAVE YOU PREVIOUSLY HAD A SIMILAR INJURY AND/OR AN INJURY TO THE SAME BODY PART? PLEASE EXPLAIN:

PROVIDE NAME OF WITNESSES:_____

IF ANOTHER PERSON NOT A TOWN EMPLOYEE CAUSED ACCIDENT, PROVIDE DETAILS & NAME/ADDRESS:

FURTHER INFORMATION YOU WOULD LIKE TO INCLUDE REGARDING YOUR INJURY/INCIDENT INCLUDING HOW THIS INCIDENT COULD HAVE BEEN AVOIDED:

INDICATE TREATMENT FACILITY:

☐ **CONCENTRA OCCUPATIONAL HEALTH CENTER LOCATION:**_____

☐ **EMERGENCY ROOM OVERNIGHT STAY** ☐Yes ☐No **HOSPITAL:**_____

☐ **OTHER - NAME, LOCATION & PROVIDER**_____

EMPLOYEE SIGNATURE:_____**DATE:**_____