Employee's First Report of Occupational Injury or Disease Worksheet

Name_____

DOB_____SS#_____Youth Work Cerificate #_____

Address_____

_____

Date of Injury_____ Time of Injury_____

Occupation_____ Supervisor_____

Location where incident happened_____

Cause of incident_____

Witnesses_____

Describe fully how incident occurred and what the employee was doing when injured:

_____

_____

Initial treatment (check all that apply)

__ No medical treatment __ Hospitalized

__ Emergency room __ Office visit

__ Hospitalized __ Other

Name and contact information for person filling out report _____

Date_____

This form must be filled out and submitted to the administrative assistant at the town hall within 24 hours.