EMPLOYEE'S REPORT OF INJURY

EMPLOYER'S NAME:____

Employee's Name:_______________________________Social Security Number:___________________________

Employee's Address:____Date of Birth:_____________________

City:____State:____________________Zip Code:______________

Home Telephone:____(_________)_________________Marital Status: ☐ M ☐ S ☐ D ☐ W

Work Telephone:____(_________)_________________Cell Phone:(__________)__________________________

Job Title:_____________________________________Department:_______________________________________

Date of hire:__________________________________Name of Supervisor:______________________________

Injured Employee's Work Shift Starts at:___________AM/PM Injured Employee's Work Shift Ends at:_____AM PM

Number of hours worked per day:____________________Per week:_______________________________________

Date of Injury/Illness:______________________________Time of Injury:_____________________☐ AM ☐ PM

Date you first reported Injury:_______________________To whom did you report:___________________________

What were you doing at time of Injury:____

Is this part of your normal job: ☐ Yes ☐ No Where did Injury occur?___________________________

When did you first notice pain:____

Give description of accident:____

____

What Injury/Illness did you sustain:______________________________**Please note: (R), (L) or both (if applicable)**

Name of Witness(es):____

Medical treatment for this Injury/Illness (Clinic and Doctor):_______________________________________
(It is your responsibility to provide a copy of the After Visit Summary/Workability immediately to your supervisor after each appointment.)

Are you still under a doctor's care: ☐ Yes ☐ No How long:____

Did you miss any work: ☐ Yes ☐ No First day of lost time?____

If still off work, when will you return:____

Have you been injured before with the same/similar injury: ☐ Yes ☐ No If yes, please give date and describe Injury:____

Are you currently employed anywhere else: ☐ Yes ☐ No If yes, where?__________________________

______________________________ ______________________________
Employee's Signature Date/Time

PLEASE IMMEDIATELY FAX OR E-MAIL THE COMPLETED FORM:
Carol Petersen I cpetersen@proresourceshr.com I (218) 847-2173 (fax) I (218) 847-0583 (direct dial)

SUPERVISOR'S REPORT OF INJURY

Employer's Name:________________________ State Injury Occurred In:________________________

Injured Employee's Name:________________________ Date/Time of Injury:______________ ________AM/PM

When were you first made aware of this Injury:________________________(Date) ____________AM/PM

Job Title of Injured Employee:____

Injured Employee's Work Shift Starts at:______________AM/PM Injured Employee's Work Shift Ends at:__________AM?PM

Where did injury occur (give exact location):____

What was employee doing when Injured (be specific):____

____

How did the injury occur (please include objects, circumstances or people directly involved)?________________________

____

Do you have any concerns about how this injury occurred: ☐ Yes ☐ No If yes, please explain?________________________

____

What measures can be taken to avoid a reoccurrence:____

____

Name of Witness(es) to Injury:____

Have you gone over the details of the incident with the Employee: ☐ Yes ☐ No?

Have you gone over the details of the incident with the Witness(es): ☐ Yes ☐ No?

Is your investigation completed: ☐ Yes ☐ No What other areas do you need to pursue?________________________

____

If needed, when will you submit a final report:____

Do you have reason to doubt the validity of this claim: ☐ Yes ☐ No If yes, explain?________________________

____

To your knowledge, has the employee ever had a similar injury: ☐ Yes ☐ No If yes, explain:________________________

____

To your knowledge, has the employee ever had any other Work Comp injuries: ☐ Yes ☐ No

Has Employee returned to work: ☐ Yes ☐ No If no, estimated return to work date:________________________

Does Employee have work restrictions: ☐ Yes ☐ No Description:____

If yes, do you have work available within those restrictions: ☐ Yes ☐ No

Does the Injured Employee Need an Interpreter to effectively communication: ☐ Yes ☐ No If yes, what language?

________________________	________________________	________________________
Supervisor's Name	Supervisor's Phone #	Date

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WITNESS POST-INJURY STATEMENT

Witness Name: ____

Employer's Name: ____

Injured Employee Name: ____

Date & Time of Injury:____ AM/PM

Name of Company you (witness) work for: ____

What were you doing at the time your co-worker was injured: ____

____

____

Describe how you co-worker was injured: ____

____

____

Did you witness the injury or observe immediately after incident: ____

____

____

From you observation, what body part was affected/injured (If applicable, (R) or (L): ________________________

____

____

Were you aware of any symptoms prior to this incident: ☐ YES ☐ NO ☐ UNKNOWN

If yes, what: ____

____

Please provide any comments that could be beneficial for claims management and/or prevention measures: ________________

____

______________________________	______________________________
Completed By (Print)	Witness Phone
______________________________	______________________________
Witness Signature	Date

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