EMPLOYEE REPORT OF INJURY / ILLNESS:

Employee's
Name:_____

Employee's
Department:_____

Employee's Supervisor: _____

Date Report filled out:_____ Date of Injury/Illness:_____

Time of Injury/Illness:_____

Date and Time reported to
Supervisor:_____

Medical Treatment offered: ____Yes ____No

Medical Treatment accepted:____Yes_____No

Transported to Cox Medical Occupational Center:_____Yes ____No

Informed Cox Medical Occupational Center that this could be Worker's Comp:
____Yes_____No

Treatment
Received:_____

_____

Prescriptions prescribed
were:_____

_____

Prescriptions filled at what pharmacy:

_____

Follow-up Appointments:_____Yes ____No Date of Follow-up:_____

First Aid Applied:_____Yes_____No

Witnesses:____Yes_____No Names of Witnesses:_____

_____

Where Injury or Illness
happened:_____

Nature of Injury or
Illness:_____

_____

Part(s) of Body
affected:_____

_____

For Employee: Please describe in your own words how injury / illness happened:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Date Employee's Report turned in to Human Resources:

_____

Employee Signature:_____Date: _____