

Workplace Injury Form

Name	Injury date
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Notes:

Has injury been reported to supervisor? <input type="radio"/> No <input type="radio"/> Yes	Injury time <input type="radio"/> am <input type="radio"/> pm
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Supervisor name	Supervisor telephone
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Describe incident that caused injury:

Current job status since injury

regular duty light duty temporary disability permanent disability off work completely

Care received following the injury <input type="radio"/> stayed on job <input type="radio"/> home rest <input type="radio"/> hospital <input type="radio"/> doctor	Doctor / hospital / ER:
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Describe treatments given to you (meds, x-rays):

Did you have pain or limitations prior to this injury? No Yes, Explain:

Have you ever had treatment for a similar problem? No Yes, Explain:

Job duties:

lift over 25lbs stooping or squatting long standing long sitting climbing

repetitive motions reaching above your head push/pulling vibration crawling

Patient signature	Date
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Initial _____