



We Manage your HR so you can Manage your Business

ASCEND HR SOLUTIONS

WORK-RELATED INJURY REPORT

Name of Injured: Social Security #:

ACCIDENT INFO (Please Print)

Date of Injury or Illness: Time of Injury: Last Day of Work After Injury: Time Employee Began Work: Date of Return to Work: Employee's Job Title When Injured: Did the injury occur on employer premises? Address of Accident: City: State: County: ZIP: What was the injury/illness (be VERY specific): Part of Body Injured (please mark side injured): Was the injury fatal?: If the employee died, when did the death occur? Was the employee treated in an emergency room? Address of ER: City: State: County: ZIP: Name of Physician: Was employee hospitalized overnight as an in-patient? If hospitalized, Hospital Name: Address of Hospital: City: State: County: ZIP: Was employee drug-tested at the hospital or clinic? If the validity of the claim is doubted please state the reason below:

CAUSE OF ACCIDENT (be VERY specific):

What happened?: Ex. "When ladder slipped on wet floor, the employee fell 20 feet." What was the object /substance that directly harmed the employee?: Ex. "Concrete floor." What was the employee doing before the incident occurred?: Ex. "Climbing a ladder while carrying roofing materials." If a person not in the company caused the accident give name & address: Hours Employee Worked: Was employee on overtime when injured? Number of Days Per Week Usually Worked By Employee:

Supervisor's Name:

Supervisor's Signature: