Manufacturing Line Workersâ€™ Compensation Report Form

Employee Information

Full Name

Employee ID

Department

Position/Role

Contact Number

Incident Details

Date of Incident

Time of Incident

Location of Incident

Description of Incident

Injury Details

Type of Injury

Body Part(s) Affected

Medical Attention Received?

If yes, please describe treatment

Witness Information

Witness Name(s)

Witness Contact

Additional Comments

Supervisor/Manager Information

Supervisor Name

Contact Number

Date Report Filed