Warehouse Injury Workersâ€™ Compensation File

Employee Name

Employee ID

Position/Job Title

Department

Date of Injury

Time of Injury

Location of Injury

Description of Incident/Injury

Type of Injury

Part(s) of Body Injured

Reported By

Date Reported

Supervisor Name

Witness(es)

Medical Provider (if applicable)

Treatment Details

Work Status (e.g., restricted, full duty, off work)

Claim Number (if assigned)

Insurance Company/Contact

Additional Notes