# Workersâ€™ Compensation Injury Report Form

## Employee Information

Employee Name

Employee ID

Department

Job Title

Supervisor

## Incident Information

Date of Incident

Time of Incident

Location of Incident

Describe the Incident

## Injury Information

Nature of Injury

Body Part(s) Affected

Was Medical Treatment Provided?

If Yes, Provide Details

## Witness Information

Witness Name(s)

Witness Statement(s)

## Additional Comments

Report Date

Signature