Workersâ€™ Compensation Injury Report

Employee Information

Full Name

Employee ID

Job Title

Department

Incident Details

Date of Injury

Time of Injury

Location

Describe the Injury

How did the injury occur?

Medical Treatment

Date First Treated

Treating Physician/Provider

Treatment Facility Name and Address

Date Returned to Work

Witness Information

Witness Name(s)

Supervisor/Employer

Supervisor Name

Date Reported