## **Healthcare Worker Injury Report**

Worker Name
Employee ID
Donartment / Unit
Department / Unit
Job Title
Date of Injury
Time of Injury
Location of Incident
Location of incident
Description of Incident
Describe the Injury
First Aid (Madical Transfer and Day ide d
First Aid / Medical Treatment Provided
Reported To (Supervisor/Manager)
Witnesses (if any)
Signature
Date Submitted