## **Employee Ergonomic Injury Report**

Employee Name	
Employee ID	
Department	
Supervisor	
Date of Injury	
Time of Injury	
Location of Incident	
Description of How Injury Occurred	
Body Part(s) Affected	
Body Fait(s) Allected	
Witnesses (if any)	
Withesses (if arry)	
Action Taken After Injury	
Action rakerraties injury	
Output from the December 1	
Suggestions to Prevent Recurrence	
Date Reported	
Employee Signature	
Supervisor Signature	