information and instructions

Employee Injured At Work

Information and Instructions

This form documents any work related injury or illness that occurs while an employee is performing job duties or is on store property for work purposes. It helps ensure the incident is properly recorded and any necessary care and follow up are provided.

What to Do

1. Attend to the employee first. Provide appropriate first aid. For a serious or life threatening condition, call 911 immediately.
2. Notify the store owner or supervisor as soon as possible, even if the injury appears minor.
3. Complete the form promptly while the details are still fresh. Record what happened immediately before, during, and after the incident.
4. Use clear, factual information. Include the location, body part affected, apparent type of injury, treatment provided, and witness information. Do not guess about the cause or severity of the injury.
5. Have the employee and owner or supervisor review and sign the completed form. If the employee can't complete or sign it, the supervisor should document why.
6. Keep the report confidential and store it with the appropriate employee or workplace safety records. Follow your store's established reporting procedure and any workers' compensation or workplace reporting requirements that apply.

This form records the incident but doesn't replace emergency care, medical documentation, workers' compensation forms, OSHA reporting, or other forms required by law or your insurance carrier.

EMPLOYEE INJURED AT WORK

INCIDENT INFORMATION

Employee Name

Job Title

Date of Incident:

Time of Incident:

DESCRIPTION OF INCIDENT

Description of Incident: *Describe what happened, include what occurred immediately before and after the incident. Use exact statements.*

Part of Body Injured

Type of Injury

Witness #1 Name

Witness #1 Contact Info (phone, email)

Witness #2 Name

Witness #2 Contact Info (phone, email)

ACTION TAKEN

First Aid Given

☐ Yes ☐ No

If Yes, By Whom

Medical Treatment Required

☐ Yes ☐ No

If Yes, By Which Agency/Facility

Did Employee Return to Work?

☐ Yes ☐ No

If Yes, Date/Time

SIGNATURES

Employee Completing Report Signature

Date

Owner/Supervisor Signature

Date

ADDITIONAL NOTES