

**Company:**

**NON-WORK RELATED INJURY OR ILLNESS REPORT**

**Personal Information:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name and address of any health insurance provider (if none, write "none"): \_\_\_\_\_

Social Security Number: \_\_\_\_ \_ -- \_\_\_\_ \_ -- \_\_\_\_ \_

**Jobsite Information:**

List your most recent job assignment: \_\_\_\_\_

Who is your on site supervisor? \_\_\_\_\_

Was this non-work related injury reported to your supervisor? Yes \_\_\_\_ No \_\_\_\_

What are your usual shift hours? \_\_\_\_ to \_\_\_\_

Regular work days? M T W TH F ST SN

**Injury Information:**

What parts of the body were injured? \_\_\_\_\_

Describe how the incident occurred/Where did it occur? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date the incident happened: \_\_\_\_\_

**Illness Information:**

Diagnosis of illness or condition: \_\_\_\_\_

Have you missed any work because of this condition? Yes \_\_\_\_ No \_\_\_\_

If yes, what is the day you first had to be off work? \_\_\_\_\_

**Treatment & Return to Work:**

Do you plan to, or have you already gone to the doctor? Yes \_\_\_\_ No \_\_\_\_

If yes, who is your treating physician? \_\_\_\_\_

Are you able to return to regular duty? Yes \_\_\_\_ No \_\_\_\_

If not, when do you expect to be able to return to regular work? \_\_\_\_\_

Have you been treated for this condition before? Yes \_\_\_\_ No \_\_\_\_

If yes, give date, treating physician, and any details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_