

Company:

Worker Interruption Report

Personal Information:

Name: _____ Phone: _____

Address _____

Name and address of any health insurance provider (if none, write "none") _____

Social Security Number: _____

JOB SITE INFORMATION:

Company where incident occurred: _____

Date incident occurred: _____

Did you finish your shift? Yes _____ No _____ Time you left work: _____

What is your usual duty? _____ Department _____

What duty were you performing at the time of the incident? _____

What are your usual shift hours? _____ to _____ Regular work days? _____

INJURY INFORMATION:

What parts of the body were injured? _____

Describe how the incident occurred/what happened? _____

Was anyone else hurt? YES _____ NO _____ If yes, give names _____

Was there any witnesses to the incident? Yes _____ No _____ If yes, give name(s) and job title(s): _____

Was the incident reported? Yes _____ No _____ Reported to? _____

If yes, Date: _____ Time: _____

Who is your on site supervisor? _____

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: _____

Corrective Actions Section:

Was the incident caused by failure of a machine or product? Yes _____ No _____

If yes, describe in detail _____

How do you think this injury or incident could have been prevented? _____

CONSENT FOR RELEASE OF INFORMATION

I Authorize my employer, _____ the right to obtain and review my medical, vocational, psysiological, and related records relative to my rehabilitation. I understand the request for such records may come directly from Jefferson Public Radio or an agent such as the insurance carrier, service company or rehabilitation firm.

I give my permission for my employer or their agent to discuss with individuals/ institution representatives and receive information from the same, pertaining to my rehabilitation.

I acknowledge that this information will be coordinated with the Workers' Compensation Department and or my employer who is in whole or part, supporting my rehabilitation.

I hereby state that the above facts are true and correct to the very best of my knowledge. I also hereby consent for release of information as described above.

Employee Signature _____

Date: _____