TAYLOR COUNTY
WORK RELATED INJURY REPORT

INJURED EMPLOYEE'S INFORMATION

Date/Time of Injury _____
Date of Report _____
Name of Employee _____ **SS#** _____
Address _____ **City/State** _____ **Zip Code** _____
Home Phone# _____ **Date of Birth** _____ **Department** _____
Employment Date _____ **Marital Status** _____ **No. of Minor Children** ___

Detailed Description of the Injury (type of injury, right/left, upper/lower, etc.)

_____
_____
_____
_____
_____

Location Where Injury Occurred (office, dayroom, parking lot, file room, county road, etc.)

_____

Witnesses Names **Address** **Phone#**

_____
_____
_____

Name of Doctor or Hospital Where Treatment was Received:

_____

Signature of Injured Employee: _____ **Date:** _____

DEPARTMENT HEAD OR SUPERVISOR'S COMMENTS

What was the Primary Cause of Injury:

_____
_____
_____
_____

Date/Description (Lifting, Hazards ID., etc.) **of Last Safety Training**_____

Recommendations to Avoid Recurrence of this Type of Injury:

_____
_____
_____

Return to Work Date _____**Full or Limited Duties** _____
First Day Unable to Work _____**Expected Length of Disability** _____

Signature of Department Head/Supervisor:_____ Date: _____

Revised April 06

Please Forward Report to Human Resources and Risk Management Office Immediately