Workers Compensation Injury Report
VSBIT

Medical treatment sought? No Yes

Work missed? No Yes

Does injury involve the back, knee or shoulder? No Yes

First Name ______________________________ Last Name __________________________________

Mailing Address:

Street ____

City _____________________________ State _________ Zip _______________________

Home telephone # ________________________ SS# ____

Gender _______________________________ Date of Birth ________________________________

Job title ______________________________ Employment location ___________________________

Date of hire ___________________________

Date of accident _________________________ Time of accident ______________________________

Date reported to employer _______________ Shift start time _______________________________

Actual location where accident happened (address) ____

On employer's premises? ☐ Exact location (classroom/playground/hall)________________________

Was machine or tool involved in the accident? ☐ Was the machine or tool defective? ☐

Object causing injury? ____

Description of accident/injury ____

Injury to what part(s) of the body____

Lost time from work? No Yes If yes please answer the next question: Date returned __________________

Complete only if seeing a doctor for <u>this</u> injury:

Physician's name ____

Practice ____

Address ____

Seen in ER? ☐ Hospitalized overnight? ☐