WorkLife HR®
Helping the Workforce of America

REPORT FORM

TO BE COMPLETED WITHIN 24 HOURS OF ACCIDENT/INJURY

INCIDENT CLASSIFICATION

Type of Incident: ____________________ Nature of Injury: ____________________
(e.g. Fall, Lifting, etc.) (e.g. Laceration, Strain, etc.)

Body Part: ____________________ Side: _____ Left _____ Right

Cause of Injury: ____________________
(e.g. Motor Vehicle Accident, etc.)

Equipment Being Used: ____________________
(e.g. Meat slicer, etc.)

Type of Activity Employee Engaged in: ____________________
(e.g. Operating crane, etc.)

Work Process Employee was Engaged in: ____________________
(e.g. Moving pallet of wood, etc.)

Was there a: _____ Safety Violation _____ Machine Malfunction _____ Motor Vehicle Accident

Comments: ____________________

Description of Injury: ____________________

Hire Date: __________ Hourly Rate: __________ Hours Worked Per Week: __________

Days Worked: ____________________ ___ Full-Time ___ Part-Time

Name of Witness: ____________________ Phone: __________

Were safeguards/safety equipment provided? ___ Yes ___ No

Were safeguards/safety equipment used? ___ Yes ___ No

OSHA Recordable? ___ Yes ___ No

WC Recordable? ___ Yes ___ No

Accident investigation conducted? ___ Yes ___ No

TREATMENT RECEIVED:

Date First Treated: ____________________

Provider: ____________________ Provider Phone Number: __________

Was treatment authorized by employer? ___ Yes ___ No

Signature of employee if they ***refuse*** to go to Doctor: ____________________

Report Prepared By: ____________________ Position: ____________________

Phone Number: ____________________ Date Completed: ____________________

Supervisor Signature: ____________________ **Employee Signature:** ____________________

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CASE INFORMATION

Incident Location: ____ On-Site ____ Off-Site

Accident Address: ______________________________

First Name: ______________ M.I.: ______ Last Name: ______________

SSN: ______________________________

Street: Address: ______________________________

City: ______________ State: ______________ Zip Code: ________

County: ______________

Home Phone Number: ______________ Cell Phone Number: ______________

DOB: __________ Race/Citizenship: __________ # of Dependents: ________

Sex: _____ Male _____ Female

Marital Status: __ Married __ Widow __ Single __ Separated __ Divorced __ Unknown

Job Title: ______________________________

INCIDENT DATES/TIMES

Is this injury job related? ____ Yes ____ No Company: ______________

Date of Injury: ______________ Time of Injury: ________ ___ a.m. ___ p.m.

Date Employer Notified: ______________________________

Date Sent to WorkLife HR: ______________________________

Last Date Worked: ______________ Time work began: ________ ___ a.m. ___ p.m.

Return to Work Date: ______________ ____ Full Duty ____ Light Duty

Date of Death: ______________