



Incident Report

Notify Office within 24 hours of injury: (888) 830-8811 Fax Completed Form to confidential Fax: (920) 968-7866

Employee Name (Print)		SS#		Home Phone Number () - -	
Home Address (Print)		City		State	Zip
Date of Hire ____/____/____	Occupation	Hourly Rate \$	Status: FT PT Casual	Date of Birth ____/____/____	
Injury Date ____/____/____	Injury Time _____ am/pm	Facility name (Full name. No initials) & unit where incident occurred (Print)			
Describe what happened to cause injury with details of the following: How event occurred? What were you specifically doing or task performing when accident/incident happened? Was/Were there objects, equipment and/or a substance that directly injured you? What was/were they? How could this injury/incident have been prevented?			Details:		
Describe injury / incident (part of body affected, symptoms, nature of injury):			Details:		
Did injury occur because of:			<input type="checkbox"/> Failure to use safety devices <input type="checkbox"/> Failure to obey rules <input type="checkbox"/> Unsafe environment <input type="checkbox"/> Other _____		
Was protective equipment available? If so was it in use?			No Yes		
Director/ Manager/Supervisor Notified			No <input type="checkbox"/> Yes <input type="checkbox"/>		
Nurses PRN Notified			No <input type="checkbox"/> Yes <input type="checkbox"/>		
Witness Name: _____			Phone Number: ____/____/____		
Have you had a similar injury in the past?			No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, please explain		

I hereby authorize any physician or any other person who has attended me to make a disclosure to my employer of any information concerning my medical history. I certify that the above statement is true and accurate and I understand that the assertion of a false worker's compensation claim is a violation of criminal code which may result in a fine and imprisonment and will result in me being terminated from employment.

Employee Signature

_____/_____/_____
Date

Facility Supervisor/Manager

_____/_____/_____
Date