LIBERTYLIVE.CHURCH

Employee Incident Report

For Office use only

Report only _____ File Claim _____

Claim # _____

Medical Report Attached _____

Date of Injury _____

Time of Injury _____

Campus HPT__ HVW__ GBR__ YKR __ SFD __ GTR __

Employee's Name _____ DOB _____

Address _____

Phone Number _____

Social Security Number _____ Date of Hire _____

Type of Injury? _____

Briefly describe the injury

_____

_____

_____

Did Injury occur on the premises? _____, location_____

_____

_____

Witness Name _____ Number _____

Witness Name _____ Number _____

When was supervisor Notified? _____ Supervisor's Name _____

Reported by _____

Date _____

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Employee Name_____ Claim #_____

Post Injury Follow Up

Employee received medical treatment: __Yes __No If yes, where? _____

Name of Physician_____

Physicians Diagnosis_____

Physicians Instructions_____

Work Status_____

Work Restrictions_____

_____

_____

Notes

Report prepared by_____ Date_____