NON EMPLOYEE INJURY REPORT

This form must be completed in detail and signed by the injured employee.

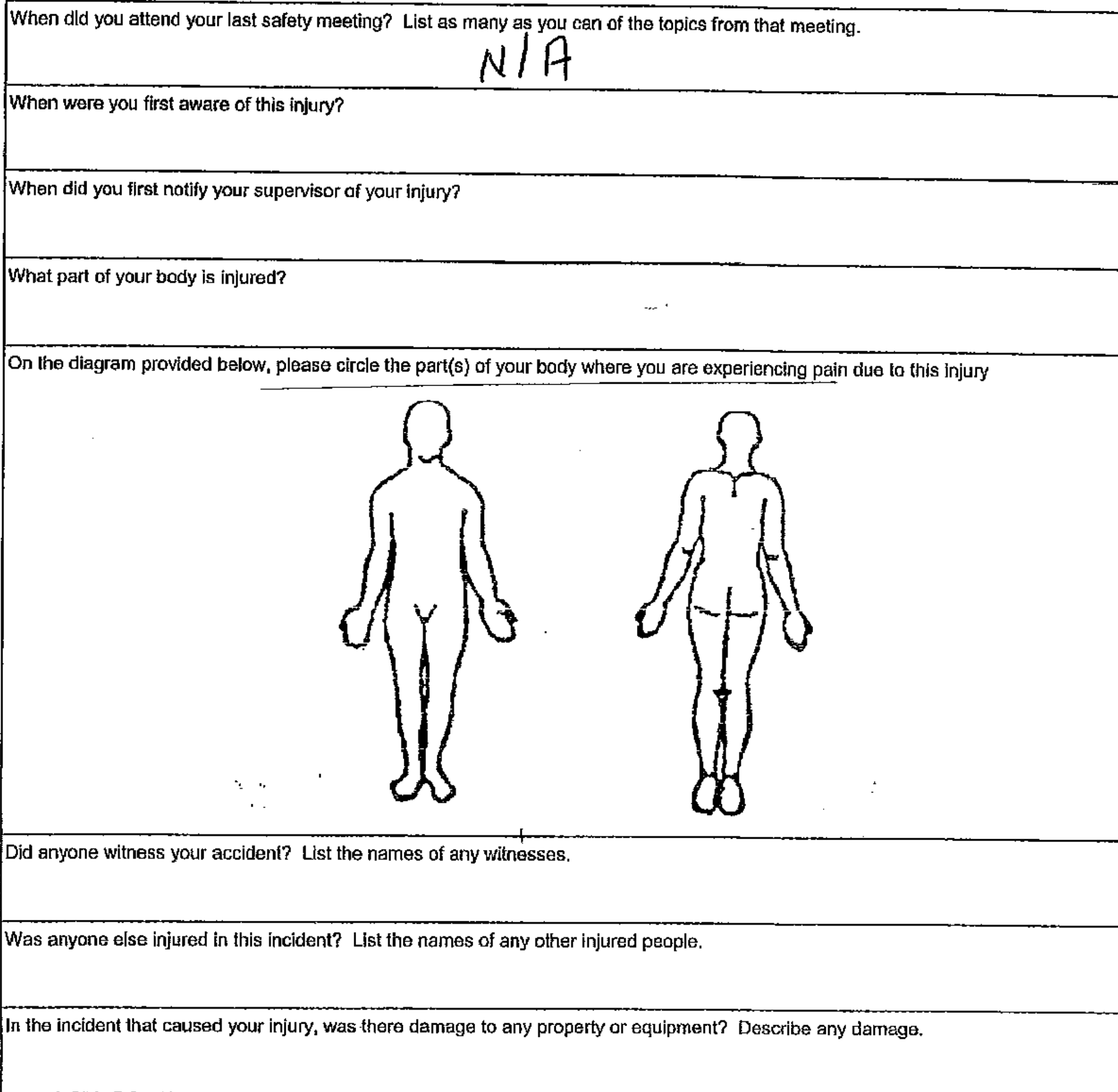
Your Name	IF STUDENT – NAME OF PARENT	
Social Security Number	City	Dept
Your Address(Street, City,State & Zip)		
Phone Number Where You Can Be Reached	Job Title	
Date of Hire	How Long In Current Position Yrs Months	
SOC. SECURITY #	DATE OF BIRTH	

Details of the Injury

Date of Injury	Time of Injury AM/PM	Date you first Lost Time
Where ON THE PROPERTY DID THE INJURY OCCUR?		
How did your injury happen? Describe in detail		
Was safety equipment was provided to you at the time of the accident?		
Was the cause of your injury due to human or machine error _______ Human _______ Machine Error		
In your opinion, what was the cause of your injury?		
What safety measures do you think can be taken to prevent an injury of the type in the future?		

NON EMPLOYEE INJURY REPORT

Revised 11/14/2001



When did you attend your last safety meeting? List as many as you can of the topics from that meeting.

N/A

When were you first aware of this injury?

When did you first notify your supervisor of your injury?

What part of your body is injured?

On the diagram provided below, please circle the part(s) of your body where you are experiencing pain due to this injury

Did anyone witness your accident? List the names of any witnesses.

Was anyone else injured in this incident? List the names of any other injured people.

In the incident that caused your injury, was there damage to any property or equipment? Describe any damage.

I certify that the information containged in this report is true and correct.

I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.

I hereby authorize the release of all medical records relating to the above noted incident to my employer, his agent or insurance company.

Employee's Printed Name　　Employee's Signature　　Date

SUPERVISOR'S INVESTIGATION OF ACCIDENT

This form must be completed for all NON - employee injuries. Please be as thorough as possible. This information will be used to prevent future injuries of this type.

Name of injured PERSON	Date of injury	Time of injury AM/PM
Date injured PERSON stopped working		Shift Start&End times
Job title when injured?	How long on this type of work? Yrs Mo	
Describe injury or illness in detail, including part of body affected, type of injury and treatment received.		
Describe the accident, include events leading up the the accident. Please be as detailed as possible.		
Describe fully any conditions which in your opinion may have contributed to this accident. Describe any human error or machine error involved.		
If machine error, has the condition been corrected? If "No", when will the condition be corrected?		
What safety equipment was provided to the employee at the time of the accident? Was it being properly used at the time of the injury?		
Were there any witnesses to this injury? If so, please identify.		
When were you first notified of this injury?		
What action has been taken to prevent a similar accident/injury?		
Is there any additional information that you feel may be beneficial to the Claims Administrator?		

Supervisor's Printed Name	Supervisor's Signature	Department	Date