

TEAM MEMBER INJURY REPORT

PROVIDE COMPLETED REPORT TO YOUR MANAGER, AREA MANAGER, OR SUPERVISOR

TYPE OF INCIDENT: <input type="checkbox"/> Physical Injury <input type="checkbox"/> Property Damage <input type="checkbox"/> Other (specify):
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TEAM MEMBER NAME:		SOCIAL SECURITY # (Last Four):	
Home Address:			
Home Phone:		Contact/Message Phone #:	
Date of Birth:		Date of Hire: Pay Rate: \$ per	
Job Title:		Name of Manager, Area Manager, and/or Supervisor:	
Date of Incident: Time of Incident:		Date & Time Reported:	
Place of Incident (address, worksite, etc.):			

DESCRIPTION
What were you doing when the accident occurred?
Were other people or objects involved? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, explain.)
List Witnesses (names, titles & how to contact them) (If a Third Party was involved in the incident, list name, address, license, and insurance information.)

PHYSICAL INJURY/ PROPERTY DAMAGE
Specify body part(s) injured/exposed & type of injury/exposure (e.g., back strain, blood in eye):
Specify property damage:

STATEMENT	
The facts as I have stated are truthful and accurate to the best of my knowledge.	
I am seeking Medical Attention at this time <input type="checkbox"/> No <input type="checkbox"/> Yes	
In the event that I need treatment in the future, I will contact my supervisor.	
I UNDERSTAND THAT I AM REQUIRED TO PROVIDE THE EARLY RETURN TO WORK LETTER and HEALTHCARE PROVIDER'S RELEASE FOR WORK FORM TO MY HEALTH CARE PROVIDER before, or promptly after, receiving treatment for a workplace injury.	
In signing this form, I permit the release of all information related to this accident to my employer and his/her authorized representative. A copy of this permission constitutes an original.	
TEAM MEMBER SIGNATURE:	DATE OF REPORT: