REPORT OF OCCUPATIONAL INJURY / ILLNESS

PERSON REPORTING INJURY	
NAME:	
RANCH: required	
BLOCK or SPECIFIC LOCATION:	
Supervisor:	
EMPLOYEE NAME: required	
EMPLOYEE'S ADDRESS: required	
DATE OF INJURY: required	
TIME OF INJURY: required	
EMPLOYEE START TIME:	
HOW INJURY OCCURED: required	
SPECIFIC ACTIVITY: required	
SPECIFIC INJURY: required	
INJURED BODY PART(s): required	
EQUIPMENT, MATERIALS, CHEMICAL USED DURING INJURY:	
INCIDENT ADDRESS: required	

MEDICAL INFORMATION

TREATING PHYSICIAN:	
PHYSICIAN ADDRESS:	
PHYSICIAN PHONE:	
DATE OF VISIT:	
TREATED IN ER:	
Yes No	
OVERNIGHT INPATIENT:	
Yes No	
HOSPITAL NAME:	
HOSPITAL ADDRESS:	
HOSPITAL PHONE:	
ADDITIONAL INFORMATION	