Report of Injury Packet

Please complete the following forms within one day of the injury. All 3 of the following forms must be filled out, signed and dated. If there are no witnesses, please state “no witness” as the witness name. Thank you.

Worker’s Report of Injury

Please complete this form after any injury occurs and return to your supervisor within one day of your injury and include any medical documentation

Company Name:		Date:
Employee Name:		Social Security #:
Job Title:	Supervisor Name:	
Address:		
Phone:	Marital Status:	Birth Date:
Date of Injury:	Time Of Injury: ☐ AM ☐ PM	
Location of Injury? (address):		
Time you began working:	Date and time supervisor notified:	
Were you on O/T when injured? ☐ Yes ☐ No	Were you paid for date of injury? ☐ Yes ☐ No	
Please describe in detail how the injury occurred:		

What was the injury? (sprain, strain, laceration, fracture, etc.)	
Part of body injured:	Body side injured: ☐ Right ☐ Left
Was treatment provided for the injury? Please give name and address of doctors and hospitals:	
Are you expected to miss any days of work? ☐ Yes ☐ No	If yes, how many?
Do you have work restrictions? If so, what?	
Did anyone (or anything) cause or contribute to the injury? If so, please list:	

Signature: _____ **Date:** _____

Completed By (please print): _____ **Title:** _____

Report of Injury Packet

Nationalpeo
A Vensure Employer Services Company

Supervisor's Report of Injury

Please complete this form after any injury occurs and return to your Work Comp Department at National PEO. All injuries should be reported immediately.

Client Name:	Employee Name:	
Address:	Address:	
Phone:	Phone:	DOB:
Business Type:	Marital Status:	SS#:
Days/week company operates: ☐ 5 ☐ 6 ☐ 7	Job Title:	
Date of Injury:	Time Of Injury: ☐ AM ☐ PM	
Employee Hire Date:	Employee's Regular Hours: to	
Time employee began working:	Has the employee returned to work? ☐ Yes ☐ No	
Employee on O/T when injured? ☐ Yes ☐ No	Employee paid for date of injury? ☐ Yes ☐ No	

Please describe in detail how the injury occurred:

What was the injury? (sprain, strain, laceration, fracture, etc.)

Part of body injured:	Body side injured: ☐ Right ☐ Left

Was treatment provided for the injury? Please give name and address of doctors and hospitals:

Is employee expected to miss any days of work? ☐ Yes ☐ No	If yes, how many?

If employee has work restrictions, is a modified duty position available? ☐ Yes ☐ No

If the accident was caused by someone else, please list their name and address:

If validity of injury is doubted, state reason here:

Supervisor Signature: _____ **Date:** _____

Supervisor Print Name: _____ **Title:** _____

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Witness Statement

Please complete this form after any injury occurs and return to your supervisor within one day of the injury

Company Name:		Date:
Witness Name:	Injured Employee Name:	
Home Phone:	Work Phone:	Cell Phone:
Address:		
Relationship to Injured Worker:		
Date of Injury:	Time Of Injury: ☐ AM ☐ PM	
Where did the injury happen? (location in building or worksite)		
Name(s) of other employees involved:		
Name(s) of other witnesses:		
The following is my statement of what I saw:		

The following is my statement of what I heard the employee say:

I hereby certify that the above statements are a true and correct account of what I observed and /or heard.

Signature: _____ **Date:** _____

Print Name: _____ **Title:** _____