

HOTWORK-USA INJURY REPORT

PART I (To be completed by employee)

1. NAME:		AGE:	DOB:	SEX: M F	HIRE DATE:	WORK STATUS: FT PT C
2. ADDRESS:		3. MARITAL STATUS: S M D				
		4. # OF DEPENDENTS:				
5. SOCIAL SECURITY NO.		OCCUPATION/DEPARTMENT:				
		SUPERVISOR: PHONE #:				
6. DATE OF INJURY: TIME AM PM		TIME STARTED WORKING TODAY: AM PM				
7. DESCRIBE INJURY: (type and area of the body)						
8. CAUSE OF INJURY: (be specific & detailed)						
9. WHERE DID THE ACCIDENT OCCUR? (Co. name & address, location in plant)						
10. WHAT WERE YOU DOING WHEN INJURED?						
11. WHAT PPE WERE YOU WEARING?						
12. WERE THERE ANY WITNESSES? YES NO IF YES WHOM?						
13. WAS THE CUSTOMER NOTIFIED? YES NO IF YES WHOM?						
14. DATE AND TIME THE INCIDENT/INJURY WAS FIRST REPORTED TO EMPLOYER: PERSON REPORTED TO:						
15. WAS FIRST AID ADMINISTERED? YES NO IF YES BY WHOM AND WHEN?						
16. NAME AND ADDRESS OF ATTENDING PHYSICIAN AND/ OR HOPITAL PROVIDING SERVICE:						
17. WAS TIME LOST FROM WORK DUE TO THE INJURY? YES NO						
18. LAST DAY WORKED: DATE RETURNED TO WORK:						
<p>I, the injured employee herein, certify that the information set forth above is true and ask the medical expenses directly related to this claim be paid. I hereby authorize any doctor or hospital to furnish to my employer or their representatives any medical information, which they may have with reference to me.</p>						
DATE		EMPLOYEES SIGNATURE				

PART II (To be completed by Employer)

1. IS PART I FULLY COMPLETED AND ACCURATE AS TO FACT? YES NO			
IF NO, ATTACH COMMENTS ON SEPARATE SHEET.			
WAS THE INCIDENT INVESTIGATED? YES NO IF YES, DID IT REVEAL ANY DATA, WHICH CONFLICTS WITH THE ABOVE REPORT OF EMPLOYEE? YES NO			
IF YES, ATTACH SEPARATE REPORT.			
2. DID EMPLOYEE LOSE TIME FROM WORK DUE TO THE INJURY? YES NO			
3. LAST DAY WORKED?		DATE RETURNED TO WORK?	
DID HE/SHE RECEIVE PAY FOR LOST TIME YES NO		IF YES, HOW MANY DAYS HRS	
PREPARED BY _____			
(Name)		(Position)	

PART III – SPRAIN AND STRAIN INFORMATION (if the injury was caused by a strain of sprain)

1. WAS THE INJURY THE RESULT OF LIFTING PUSHING PULLING OTHER:			
2. WEIGHT OF THE OBJECT MOVED		WAS HE/SHE MOVING IT ALONE? YES NO	
3. WAS THIS NORMAL DUTY FOR THEM? YES NO		HOW LONG HAVE THEY DONE THIS WORK? YRs MNs	
4. TO YOUR KNOWLEDGE DID ANYTHING UNUSUAL HAPPEN?			
5. DO THEY HAVE A HISTORY OF SIMILAR INJURIES OR CONDITIONS (list conditions, give dates, attach medical data)			
6. PLEASE OBTAIN A STATEMENT FROM ANY KNOWN WITNESS.			

COMPLETED BY _____