REPORT OF INJURY OR INCIDENT

All questions must be answered. If a question does not apply, please write (N/A)

Employee fills out this section

1. Name of injured or involved employee ______________________
First Middle Last

2. ( ) ( ) Male Female

3. Age ________

4. How Long Employed with Heim ______________________

5. Social Security Number ______________________

6. Date of birth ______________

7. Married Yes ( ) No ( )

8. Home address ______________________
____
County: ______________________

9. Telephone (___) ______________

10. No of Children Under 18 ______________________

11. Department / Job Title ______________________

12. Date of injury of incident ______________________

13. Time of injury or incident ______________________

14. Location where injury or incident occurred (Including City, State, County & Zip Code)
____

15. Cause of injury or incident (describe how & why injury or incident occurred)______________________
____
____
____

16. Nature of injury or incident (identify body part injured as specific as possible)______________________
____
____

17. If this notice was not filed with your foreman within 2 working days after the injury, explain the reason for the delay.____
____

18. Name, address and phone number of physician first providing medical care.______________________
____

19. Type of medical care provided (stitches, cast, medication, removal of foreign body, days off work etc…).____________
____
____

20. I certify that the information provided above is true & correct to the best of my knowledge.

______________________ Signature & title of injured employee

______________________ Date of report

21. Was there a witness? ( ) Yes ( ) No

Statements of Witness (described what you saw, heard or know about this injury or incident)______________________
____
____

22. Witness signature ______________________

23. Date signed ______________________

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Foreman or most immediate supervisor fills out this section

24. Foreman receiving report (Print) ______________________

25. Date and time report received ______________________

26. Did employee leave the job site?
( ) No ( ) Yes
If yes, please state day and hour ______________________

27. Date employee first received medical care for the injury or incident
______________________ (mm/dd/yyyy)

28. Was the Injury or incident a result of an:

A.	Unsafe Act	( ) Yes	( ) No
B.	Mechanical Defect	( ) Yes	( ) No
C.	Other	( ) Yes	( ) No

____
____
____

29. Does your knowledge of the facts about this injury or incident agree with the statements of the employee and or witness?
( ) Yes ( ) No If no, furnish a detailed explanation.______________________
____
____
____

30. How could the injury or incident have been avoided?______________________
____

31. Job Name & Number ______________________

Foreman's signature ______________________

Safety Director fills out this section

32. Date Claim was File: ______________________

33. Claim Number Assigned: ______________________