REPORT OF INJURY RELATED TO EMPLOYMENT

EMPLOYEE / WAGE

Name of Injured Employee				Social Security No.	
Home Address (City, State, Zip Code)			Home Phone Number		
Sex Male ___ Female ___ Unknown ___		Date of Birth	Employment Status Full Time ___ Part Time ___ Other _____		
Department		Date Hired	Job Title		State of Hire MISSISSIPPI
Annual Pay Rate (Yearly)	# Days Worked per Week	Date if Injury	Time of Injury	Full Pay for Day of Injury? Yes ___ No ___ Did Salary Continue? Yes ___ No ___	
Describe the Injury (Be specific, e.g.; burned forearm).					
How did the injury occur? State what the employee was doing when the injury and circumstance leading to the injury.					
Was there a malfunction of equipment? YES ___ NO ___		If yes, describe malfunction:			
Was first aid administered? YES ___ NO ___		If yes, by whom was the first aid administered?			

OCCURRENCE / TREATMENT

Time Employee Began Work _____ AM _____ PM	Date of Injury / Illness	Time of Occurrence _____ AM _____ PM	Last Work Date
Contact Name Phone Number		Date Employer Notified	Date Disability Began
Did injury / illness exposure occur on employers premises? Yes ___ No ___	Type of Injury / Illness	Part of the Body Affected	
Department or Location Where Accident or Illness Exposure Occurred		All Equipment, Materials, or Chemicals Employee was using when accident or illness exposure occurred	
How Injury / Abnormal Health Condition Occurred. Describe the Sequence of Events and Include any Objects or Substances that Directly Injured the Employee or Made the Employee ill.			
Date Return(ed) to Work	Were Safeguards or Safety Equipment Provided? Yes ___ No ___ Were they used? Yes ___ No ___		
Physician / Health Care Provider (Name & Address)	Hospital (Name & Address)	WITNESS (Name & Phone No.)	

***INITIAL TREATMENT ***

___ No Medical Treatment ___ Minor: By Employer ___ Minor Clinic/Hosp ___ Emergency Care ___ Hospitalized > 24hrs ___ Future Major Medical / Lost Time Anticipated