CENTURY DRYWALL INC.
Injury Reporting Report

EMPLOYEE REPORT:

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____ DATE OF BIRTH _____ AGE _____

FULL ADDRESS No. & Street _____ CITY _____ STATE _____ ZIP CODE _____ SINGLE ____ MARRIED ____

SOCIAL SECURITY # _____ NUMBER OF DEPENDENTS _____ SEX: M____ F____ PHONE NUMBER ( ) _____

DEPARTMENT _____ JOB TITLE _____ EMPLOYEE CLOCK NO. _____

LOCATION OF INCIDENT _____ DATE OF INCIDENT _____ TIME OF INCIDENT _____ AM PM

_____

_____ OFF PREMISES? YES____ NO ____

SPECIFIC AREA WHERE INCIDENT OCCURRED _____

_____

DESCRIBE AND ILLUSTRATE (AT RIGHT) YOUR INJURY: _____

DOMINANT HAND:
RIGHT____
LEFT____

_____

DESCRIBE THE INCIDENT _____

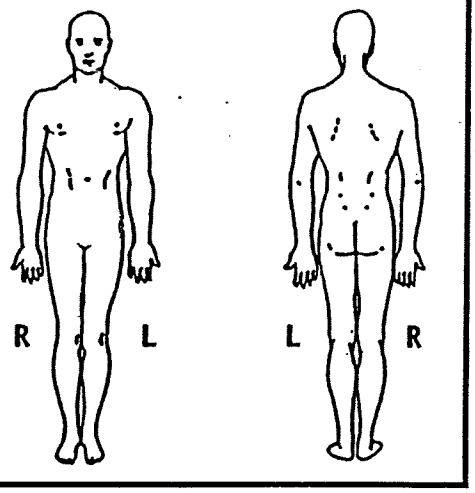
_____

_____

NAME OF WITNESS TO INCIDENT (PRINT) _____

EMPLOYEE SIGNATURE _____ DATE _____

INDICATE ON THESE FIGURES THE AFFECTED BODY PARTS:



SUPERVISOR INITIAL REPORT:

SUPERVISOR NAME: _____

WAS THERE A SPECIFIC INCIDENT/ACCIDENT? Y____ N____ UNKNOWN____ DID YOU WITNESS THE INCIDENT/ACCIDENT? Y____ N____

GIVE A STEP BY STEP DESCRIPTION OF WHAT YOU UNDERSTAND TO HAVE HAPPENED _____

_____

_____

IF YOU PROVIDED CARE, BRIEFLY DESCRIBE INJURY AND CARE _____

_____

EMPLOYEE SENT TO CLINIC? Y____ N____ WHERE _____ TIME _____ AM PM

BODY PART _____ INJURY TYPE _____ PART-TIME EMPLOYEE Y____ N____

SUBSTANCE/OBJECT DIRECTLY CAUSING INJURY _____

DATE: _____ HOSPITAL NAME/ADDRESS _____ SWR# _____

DID EMPLOYEE RETURN TO WORK SAME DAY? Y____ N____ WAS INJURY LOST TIME? Y____ N____ IF YES, DATE LOST TIME BEGAN / /

SENT HOME REMAINDER OF DAY: Y____ N____ JOB MODIFICATION? Y____ N____ DATE ENDED / /

JOB MODIFICATION BEGAN / / ENDED / / DID EMPLOYEE DIE Y____ N____

OSHA RECORDABLE? Y____ N____

EXPLAIN _____ REASON: _____

_____ DETAILED ACCIDENT INVESTIGATION Y____ N____

SIGNATURE _____ FIRST REPORT FILED? Y____ N____

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