CENTURY DRYWALL

Injury report form

EMPLOYEE REPORT:

Last Name _____ First Name _____ MI _____ DOB _____ Age _____

Address _____ City _____ State _____ Zip Code _____ last 4 of SS# _____

Phone No. _____ Date of Incident _____ Time of Incident _____ AM ☐ PM ☐

Trade _____ Jobsite _____ Foreman _____

Area incident occurred _____ Job Task _____

Incident description

Dominant hand
Right ☐
Left ☐

Name of Witness _____

Employee Signature _____ Date _____

SAFETY COORDINATOR/ SUPERVISOR:

CLAIM TYPE	
INCIDENT ONLY	☐
FIRST AID ONLY	☐
MED ONLY	☐

INJURY TYPE					
ABRASION	☐	FRACTURE	☐	STRAIN/SPRAIN	☐
DEBRIS IN EYE	☐	LACERATION	☐	OTHER	☐
CONTUSION	☐	PUNCTURE	☐		

CHECK OFF AFFECTED BODY PARTS			Left	Right
HEAD	☐	SHOULDER	☐	☐
FACE	☐	UPPER ARM	☐	☐
NECK	☐	LOWER ARM	☐	☐
UPPER BACK	☐	ELBOW	☐	☐
LOWER BACK	☐	WRIST	☐	☐
CHEST	☐	HAND	☐	☐
ABDOMEN	☐	BUTTOCKS	☐	☐
PELVIS/GROIN	☐	HIP	☐	☐
MOUTH	☐	THIGH	☐	☐
NOSE	☐	LOWER LEG	☐	☐
	☐	KNEE	☐	☐
		ANKLE	☐	☐
		EYES	☐	☐
		EARS	☐	☐

Did you witness the incident/accident? Yes ☐ No ☐ Was proper PPE in use? Yes ☐ No ☐

Describe the incident

If you provided First Aid , briefly describe injury & care

Was employee sent for medical evaluation? Yes ☐ No ☐ Where _____ Time _____

Who provided transportation to medical facility? _____

Source or cause of injury _____ Task at time of Incident _____

How long has the employee been performing this task? _____

What equipment was used at the time of the incident? _____

Did the employee return to work same day? Yes ☐ No ☐

Date expected to return _____ Was the employee sent home remainder of the day? Yes ☐ No ☐

Safety Coordinator/ Supervisor Signature _____ Date _____