



## EMPLOYEE INJURY REPORT

COMPLETE AND SUBMIT BOTH PAGES OF THIS REPORT TO RESOURCE MANAGEMENT, INC. WITHIN TWENTY-FOUR (24) HOURS OF THE INJURY:

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### EMPLOYEE INFORMATION

CLIENT COMPANY: \_\_\_\_\_ EMPLOYEE'S DATE OF HIRE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
EMPLOYEE NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_  
EMPLOYEE ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP  
EMPLOYEE PHONE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
EMPLOYEE MARITAL STATUS:  SINGLE  MARRIED NUMBER OF DEPENDENTS: \_\_\_\_\_  
EMPLOYMENT STATUS:  FULL-TIME  PART-TIME  TEMPORARY  
EMPLOYEE JOB TITLE: \_\_\_\_\_  
WAGE: \$ \_\_\_\_\_ PER  HOUR  YEAR  
SUPERVISOR NAME: \_\_\_\_\_ SUPERVISOR TITLE: \_\_\_\_\_  
SUPERVISOR EMAIL: \_\_\_\_\_ SUPERVISOR PHONE: \_\_\_\_\_

### INJURY INFORMATION

DID INJURY OCCUR ON COMPANY PREMISES?  YES  NO

IF NO, LIST THE ADDRESS WHERE THE INJURY OCCURRED:

STREET CITY STATE ZIP

WHERE INJURY OCCURRED (I.E. LOADING DOCK NORTH): \_\_\_\_\_

DATE OF INJURY: \_\_\_\_/\_\_\_\_/\_\_\_\_ TIME OF INJURY: \_\_\_\_\_  AM  PM

EXPLAIN IN DETAIL WHAT PART(S) OF BODY WERE INJURED AND THE TYPE OF INJURY (I.E. BRUISED RIGHT HAND, SPRAINED LEFT KNEE): \_\_\_\_\_

EXPLAIN THE DETAILS OF THE INCIDENT. LIST ANY TOOLS/MACHINERY THAT EMPLOYEE WAS USING AT THE TIME OF INJURY: \_\_\_\_\_

WAS ANY SAFETY EQUIPMENT BEING USED?  YES  NO IF YES, DESCRIBE: \_\_\_\_\_

WERE THERE ANY WITNESSES TO THE INCIDENT?  YES  NO  
LIST NAMES AND PHONE NUMBERS OF ALL WITNESSES: \_\_\_\_\_

*\*PLEASE ATTACH A WRITTEN STATEMENT FROM EACH WITNESS TO THIS FORM*

HAS EMPLOYEE HAD A PREVIOUS OR SIMILAR INJURY?  YES  NO

DATE OF PREVIOUS INJURY: \_\_\_\_/\_\_\_\_/\_\_\_\_

DO YOU DOUBT THE VALIDITY OF THE CLAIM?  YES  NO IF YES, WHY? \_\_\_\_\_

**TREATMENT INFORMATION**

WAS FIRST AID ADMINISTERED ON-SITE?  YES  NO IF YES, DESCRIBE: \_\_\_\_\_

DID THE EMPLOYEE RECEIVE ADDITIONAL MEDICAL TREATMENT?  YES  NO

MEDICAL CENTER/DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

MEDICAL CENTER/DOCTOR ADDRESS: \_\_\_\_\_

DATE AND TIME EMPLOYEE LEFT WORK: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ At \_\_\_\_\_  AM  PM  
STREET CITY STATE ZIP

WAS EMPLOYEE RELEASED TO FULL DUTY?  YES  NO

WAS EMPLOYEE RELEASED TO LIGHT DUTY  YES  NO

EXPECTED DURATION OF LIGHT DUTY: \_\_\_\_\_

HAS THE EMPLOYEE MISSED ANY WORK?  YES  NO IF YES, HOW MANY DAYS? \_\_\_\_\_

DATE EMPLOYEE IS EXPECTED TO RETURN TO WORK: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

*\* FAX ANY DOCTOR'S NOTES OR RETURN TO WORK SUMMARIES WITH INJURY REPORT.*

**FOR RMI USE ONLY:**

CLAIM NUMBER: \_\_\_\_\_

DATE REPORTED: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_