CEDARCREEKCHURCH

Employee Incident/Injury Report

All lines MUST be fully completed by the employee.

Name_____

Date of injury **or** onset of symptoms_____ Time_____ ☐ am ☐ pm

Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, write on the back of this form). **Be specific - name any objects or substances involved:**_____

_____

_____

_____

_____

_____

_____

_____

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who? _____

Did you report this incident to anyone? ☐ Yes ☐ No If not, why not? _____

If yes, to whom did you report it? _____ Title/Position_____

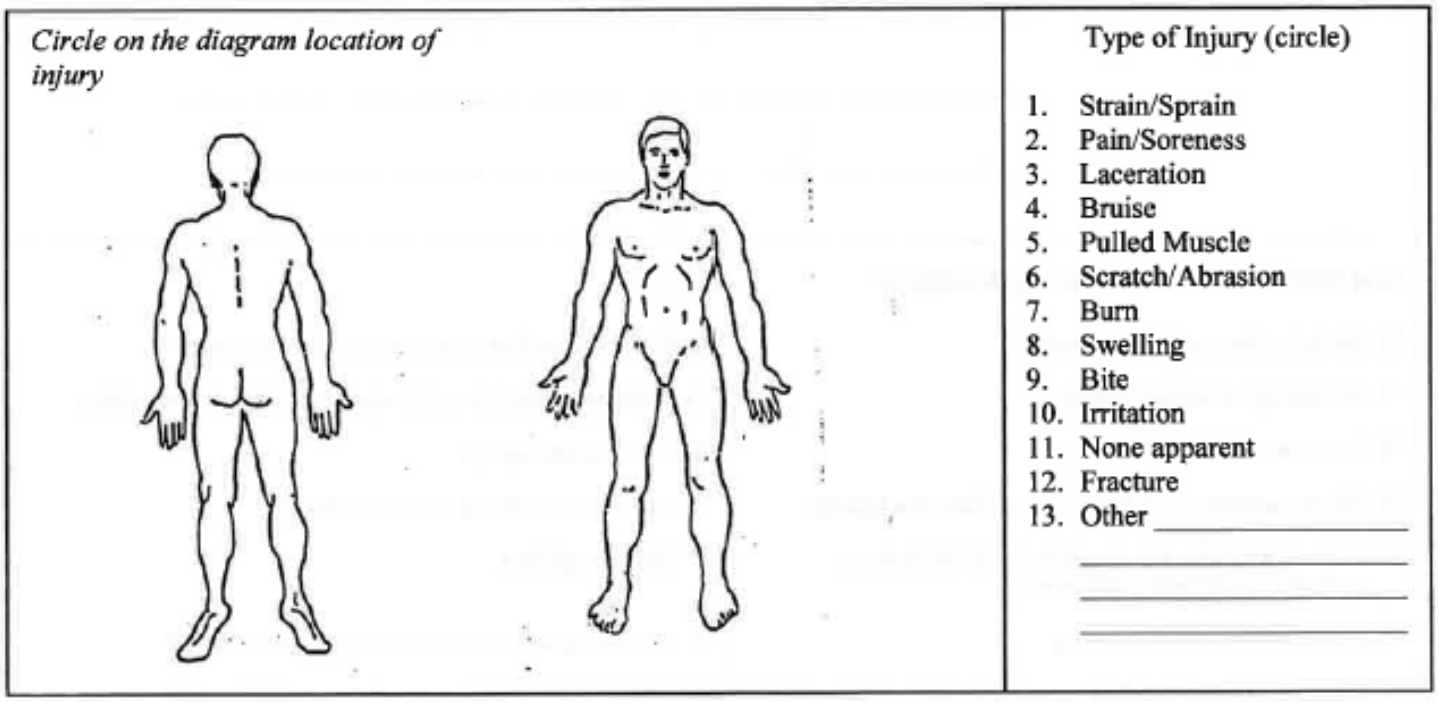
When did you report this information to them? Date _____ Time_____ ☐ am ☐ pm

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):

_____

_____

Circle on the diagram location of injury



Type of Injury (circle)

1. Strain/Sprain
2. Pain/Soreness
3. Laceration
4. Bruise
5. Pulled Muscle
6. Scratch/Abrasion
7. Burn
8. Swelling
9. Bite
10. Irritation
11. None apparent
12. Fracture
13. Other _____

_____

_____

_____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe:

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_____
_____
_____
_____

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when? _____

Where? _____
If treatment was not sought immediately, explain why:
_____
_____
_____
_____
_____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury/symptom? _____
By whom or where? _____
Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury:
_____
_____
_____
_____

Medical Release

Under current workers' compensation law, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **CompManagement, LLC.** A copy of this form will serve as the original.

Employee Name (print) _____

Employee Signature_____

Date (required) _____