IREDELL COUNTY WORK RELATED INJURY/ILLNESS REPORTING FORM

Created: 9/6/2018

Employee Section (to be completed by Employee):

Employee Name: Cell Phone #: Date of Birth:

Full Home Address: Home Phone #:

Sex: ☐ Male ☐ Female Department:

Job Title: Work Phone #:

Employee Email: Date of Injury: Time of Injury:

Physical Location of Incident:

Explain in your own words how the injury/accident occurred:

Explain in your own words the type of injury that occurred including specific body part:

Witnesses? If so, give full names and contact information of each witness:

EMPLOYEE PRINTED NAME AND **SIGNATURE:**

Supervisor Section (to be completed by Supervisor):

Date Supervisor notified of incident: Supervisor Full Name:

Supervisor Job Title: Supervisor Phone #:

Supervisor Email:

Did employee seek medical attention? ☐ Yes ☐ No Taken by Emergency Transportation: ☐ Yes ☐ No

If yes, Name of Treating Facility: Address of Facility:

Was the employee hospitalized? ☐ Yes ☐ No Hospital Name:

Other than the day of the injury, did employee lose any time from work? ☐ Yes ☐ No

Was the employee placed on light duty? ☐ Yes ☐ No Were safeguards/safety equipment provided? ☐ Yes ☐ No Used? ☐ Yes ☐ No

If yes, please explain what the employee is doing for light duty:

Do you question the validity of this claim? ☐ Yes ☐ No

If yes, please explain why:

Employee Hours of Work (eg: 8 hour days, 12 hour days, etc.?

Corrective Action Taken, if Any as a Result of the Investigation:

* Please attach a copy of the incident investigation report, police report if available, pictures, videos or any other pertinent information.
* Please send all doctor's notes to the Risk Management Manager.

SUPERVISOR PRINTED NAME AND **SIGNATURE:**

Human Resources Section (to be completed by HR Representative):

Employee SS # : Employee Date of Hire: Employee Hourly Rate of Pay:

Entered into Claim Capture: Form 19 Received: ☐ Employee Dr. Notes Received:

Incident Investigation Form Reviewed and Received: ☐

HUMAN RESOURCES REPRESENTATIVE SIGNATURE: