
Employer Injury Report

Employee Name: _____ Position: _____

D.O.B.: _____ SS#: ___-__-____

Company Name: _____ Supervisor: _____

Date/Time of Accident: _____ Location of accident: _____

Medical attention sought: _____ If yes where: _____

Was a drug screening completed: _____ Where: _____

Type of injury: _____

Location of Injury: _____

Statement of
injury:_____
_____
_____
_____
_____
_____
_____
_____

Print Name: _____ Date: _____

Signature: _____ Phone#_____

***Fax to: 904-930-4271***