Worker's Comp Claim # ______________

OSHA Log # ______________

REPORT OF INCIDENT

Date of Incident: ______________ Location (Store) of Incident: ______________

Date Employer Notified: ______________ Time of Incident: ________ a.m. p.m.

If fatal, give date of death: ______________ Time Employee began work ________ a.m. p.m.

Please Check: ☐ Employee ☐ Customer ☐ Male ☐ Female

Name: ______________ Daytime Phone: ______________

Address: ______________ Evening Phone: ______________

City, State, Zip: ______________ Date of Birth: ______________

Date of Hire: ______________ Social Security #: ______________

Pay Rate: ______ Job Title: ______________

Signature of Manager on Duty at Time of Incident: ______________

Witness Information:

Name: ______________ Address: ______________

Daytime Phone: ______________ City, State, Zip: ______________

Injury Description: ______________

(Describe sequence of events ______________

that directly injured party, or ______________

caused the disease or death) ______________

Area of Body Injured: ______________ Has this area of your body been injured before? ________

If yes, Explain: ______________

Medical Treatment Information:

Was Medical Treatment Sought? ☐ Yes ☐ No

Name of Physician & facility: Did patient go to emergency room? ☐ Yes ☐ No

______________ Was patient hospitalized overnight? ☐ Yes ☐ No

______________ Last day worked: ________ Return to Work Date: ________

Signature of Injured Party: ______________ Date ________

Witness to Signature of Injured Party: ______________ Date ________

Fax completed form to (270) 465-8187. Questions call (270)465-8675. 1/08