INJURY AND ILLNESS REPORT FORM

Environmental Health & Safety

Employee Name: ______________________

Date of Injury: ______________ **Time Injury Occurred:** ______________

Department: ______________ **Job Title:** ______________

Contact #: ______________ **Employee's Start Time:** ______________

Home Address: ______________________

City/State/Zip Code: ______________________

Birth Date: ______________ **Hire Date:** ______________

Specific Location of Incident ***(bldg, floor, room #, inside/outside)*** **:** ______________

Injured Body Part: ☐ Face/Neck ☐ Head ☐ Eyes ☐ Legs ☐ Hands ☐ Back ☐ Arms ☐ Feet ☐ Respiratory ☐ Other, specify ______________

Type of Injury/Illness: ______________________

Describe how Injury/Illness Occurred: ______________________

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Describe Contributing Factors/Events (Describe events preceding the Injury/Illness): ______________

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Witnesses/Others: ______________ **Contact #:** ______________

Supervisor: ______________ **Contact #:** ______________

Does Employee Need Medical Treatment? ☐ **YES** ☐ **NO**

I agree with the information above.

Employee Signature: ______________ **Date:** ______________

Supervisor Signature: ______________ **Date:** ______________

Name of Treating Facility: ______________________

Physician's Name: ______________ **Phone #::** ______________

Address: ______________ **City/State/Zip Code:** ______________

Please Fax Completed Form to EHS General Safety Office (404) 894-5042

If Medical Attention was given, Supervisors Must Notify: DOAS 24 Hour Injury Report Line – (877) 656-7475