PRELIMINARY REPORT OF INJURY

Employee Information

Name of Injured:		Report Date:
Address:		Phone Number:
City, State Zip:		County:
Does Employee Speak English? ☐ Yes ☐ No	Race:	Ethnicity:
Marital Status:	Spouse's Name:	Number of Dependent Children:

Doctor Information (doctor seen for this injury)

Doctor's Name:	
Doctor's Address:	Phone Number:

Injury Information

Date of Injury:	Time of Injury:	Date Lost Time Began:
Nature of Injury:	Part of Body Injured or Exposed:	
How and Why Accident Occurred (detail):		
Was the Employee Wearing Safety Equipment at the Time of the Injury? (Safety Belt, Eye Protection, Seat Belt, etc.) ☐ Yes ☐ No		
Cause of Injury (fall, tool, machine, etc.):	Worksite Location of Injury (stairs, dock, etc.):	Was Employee Performing Regular Duties? ☐ Yes ☐ No
Address Where Injury or Exposure Occurred Including County (be specific):		
Witnesses:	Expected Return to Work Date:	
Supervisor's Name:	Date Reported:	
Supervisor's Signature:		

Revised: 08/20/2025