Work-Related Injury Report Form

This form must be completed within 24hours of injury/illness/near miss by the employee or the supervisor, if the employee is unable to. The completed form should be submitted to the Human Resources Office at TES Staffing as soon as possible, to the following contact.

Attention: Sarah Fricano
Fax: (585) 232-2147
Phone (585) 232-4880 ext 110
Email: sfricano@tesstaffing.com

Note: If applicable, the Workers Comp carrier will be notified by TES Staffing once the form has been reviewed by the Human Resources Dept.

PERSONAL INFORMATION			
Print Employee Name (Last, First, MI):			**Today's Date:**
Home address (street, city, zip)			**Home phone number:** **Birth date**
Supervisor's name & phone number			**Social Security#**
Employee Job Title and Duties:			
Employee work schedule: ☐ **Full-time** ☐ **Part-time**	**Employee ID #:**	☐ **Male** ☐ **Female**	**I am reporting a work related:** ☐ **Injury** ☐ **Illness** ☐ **Near miss**

INJURY / ACCIDENT INFORMATION	
Client Location/Department and Address:	
Date of Injury _____ **Time employee began work** _____ ☐ **AM** ☐ **PM** **Time of injury** _____ ☐ **AM** ☐ **PM** **Date Supervisor was notified of injury**_____	**Work Site Location of Injury:** **Is this work site the employee's normal work location?** ☐ Yes ☐ No **If no, please explain:** _____ _____
Names of witnesses, if any:	**What part of employee's workday did the injury/illness/near miss occur?** ☐ **Entering or leaving work** ☐ **Doing normal work activities** ☐ **During meal period** ☐ **During break** ☐ **Working overtime** ☐ **Other**_____
Employees Work Week: (Days and shifts normally worked- i.e. Monday-Friday 8am-5pm) **Days worked:** ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday	

Start Time:							
End Time:							

What part of the body was affected or injured? _____

What was the nature of the injury/illness/near miss? Describe in detail. _____

_____

_____

Describe fully what happened? What was employee doing prior to the event? _____

_____

_____

Identify the object or substance that caused the injury/illness/near miss? _____

_____

What action has been taken to prevent this recurrence? _____

_____

Was the employee exposed to a foreign substance or chemical(s)? ☐ Yes ☐ No

If yes, name of substance or chemical(s): _____

What equipment or tools were being used when incident occurred, if any? _____

_____

What type of safety training has the employee received? _____

_____

Was any personal protection equipment being used: (example: safety goggles, gloves, safety shoes, etc.) _____

_____

What medical action was taken? ☐ No Medical Action ☐ On-site First Aid ☐ Went to Emergency Dept.

☐ Went to Urgent/Immediate Care Facility ☐ Other (please explain)_____

Describe any First Aid given at the scene of the accident/Injury: _____

_____

Are you aware if any medications were prescribed to the employee in relation to this injury?

☐ Yes ☐ No ☐ Unknown ☐ Other _____

Employee signature: _____ **Date**_____

Supervisor signature: _____ **Date** _____