

REPORT OF EMPLOYEE INJURY

County of Knox

EMPLOYEE PORTION:

FILL OUT THIS REPORT COMPLETELY AND SUBMIT IT TO YOUR SUPERVISOR WITHIN 24 HOURS OF RECEIVING THE INJURY.

Employee Name:		Employee Mailing Address:		Employee contact number(s): Home Phone: Cell Phone if Different:	
Date of Injury:	Time of Injury:	Day of Injury: <input type="checkbox"/> Mon. <input type="checkbox"/> Wed. <input type="checkbox"/> Fri. <input type="checkbox"/> Tues. <input type="checkbox"/> Thurs. <input type="checkbox"/> Sat. <input type="checkbox"/> Sun.		Date Reported:	Supervisor reported to (Name and Title):
Shifts You Work:		From:	To:	From:	To:
<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday		_____	_____	<input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	_____
Witness 1 (Name and Title):				Work Phone:	
Witness 2 (Name and Title):				Work Phone:	
Do you work for another Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, name of employer:		Date & Time you returned to work (if applicable):	Location/Address of Accident:
Object, substance, or exposure which directly brought about your injury:					
Describe your (check one) <input type="checkbox"/> Injury <input type="checkbox"/> Disease in detail which brought about your injury:					
Doctor(s): Name: Address:			Hospital(s): Name: Address:		

SUPERVISOR PORTION:

CHECK THIS REPORT FOR COMPLETENESS AND SUBMIT IT TO YOUR DEPARTMENT MANAGER ASAP

Did injury cause loss of time (other than On day of injury)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date last worked:	Time lost from work on day of injury: hrs.	Will this injury restrict employee's normal job duties?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If restricted, for approximately how many days?
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(Continued on the next page)

A. DESCRIPTION (if different, or if you have more information, than what's in the narrative by the employee above) OF INJURY/ILLNESS ~ BODY PART AFFECTED ~ TREATMENT:

Employee _____ Date _____

Immediate Supervisor _____ Date _____

Department Manager _____ Date _____

Supervisor Accident/Incident Analysis has been completed, reviewed and is attached? Yes No

**DEPARTMENT MANAGERS – TURN THIS FORM INTO THE COUNTY ADMINISTRATOR
WITHIN 24 HOURS FROM WHEN THE INJURY IS REPORTED TO YOU**