Reset Form

Worker's Compensation Injury Report

This form should be completed by the injured employee and their supervisor.

Employees can provide details about an injury by completing and signing this form and submitting it to the Office of Human Resources.

For emergency care, go to the closest emergency room. Follow-up care and care for non-emergencies must be provided by one of the approved providers on the worker's compensation panel list.

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Employment Status: Full-Time ☐ Part-Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

Job Title: _____

Date of Injury: _____

Time Employee Began Work: _____ Time of Injury: _____

Date Employer Notified: _____ Date Returned to Work: _____

Type of Injury or Illness: _____

Parts of Body Affected: _____

Cause of Injury: _____

Location of Incident (building/ indoor/outdoor location): _____

Has employee been treated for a similar incident in the past? Yes ☐ No ☐

Has employee been treated for injury involving this part of the body? Yes ☐ No ☐

Medical Treatment: _____

Were safeguards or safety equipment provided? Yes ☐ No ☐

Were safeguards or safety equipment used? Yes ☐ No ☐

List equipment, materials, or chemicals that employee was using when accident or illness exposure occurred.

How did injury or illness/abnormal health condition occur?
Describe the sequence of events and include any objects or substances directly responsible.

Supervisor

Name of Supervisor:_____ Signature:_____

Witness

Name of Witness:_____ Witness Phone Number:_____

I wish to waive any medical treatment and I realize in doing so that any treatment received after the fact, I will incur any associated costs and Cabrini will not be responsible.

Name Print:_____ **Signature:_____**

Person Completing This Form -By signing this form, I acknowledge that I have received a copy of the Worker's Compensation list of panel doctors, which I am able to visit to treat this work related injury

Name:_____

Title:_____ Phone Number:_____

Signature:_____ Date:_____