

EMPLOYEE INJURY/INCIDENT REPORT FORM

Town of Marana

THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE AND FORWARDED TO THE EMPLOYEE'S SUPERVISOR AS SOON AS POSSIBLE AFTER THE INJURY. If additional space is required, use the back of the form.

DEPARTMENT:

1. PRINT NAME OF AFFECTED EMPLOYEE:

2. DATE AND TIME OF INJURY/INCIDENT:

3. WHAT TIME DID YOU BEGIN WORK?

4. DESCRIBE HOW THE INJURY/INCIDENT OCCURRED: (Include location, equipment involved, job duty performing, and details to fully explain)

5. WHAT WERE YOU DOING JUST BEFORE THE INCIDENT OCCURRED?

6. PROVIDE NAMES OF ALL WITNESSES AND ANY OTHER PERTINENT INFORMATION:

7. DESCRIBE THE NATURE OF YOUR INJURY (Include specific body parts, etc):

8. NAME AND LOCATION OF TREATMENT PROVIDER:

**9. HAVE YOU PREVIOUSLY HAD A SIMILAR INJURY AND/OR AN INJURY TO THE SAME BODY PART?
PLEASE EXPLAIN:**

**10. FURTHER INFORMATION YOU WOULD LIKE TO INCLUDE REGARDING YOUR INJURY/INCIDENT,
INCLUDING HOW THIS COULD HAVE BEEN AVOIDED:**

I CERTIFY THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE

EMPLOYEE'S SIGNATURE and DATE