Employee's Report of On-the-Job Injury/Illness

To be completed by the employee only - please provide full details where applicable

Name of Employee: Last, First, Middle	**Social Security #**:	**Phone Number:**
Home Address: (Include Zip)	**Date of Birth:**	
	Hire Date:	**Hire State:**
Injury Reported to:	**# of Dependents**:	**Marital Status:** Single ☐ Married ☐

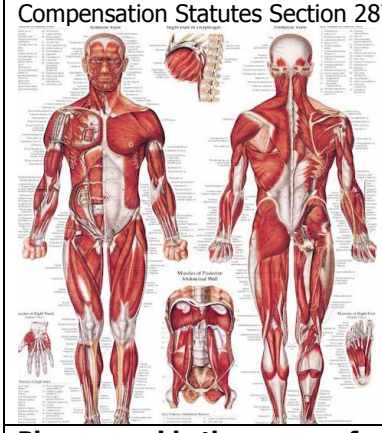
Date of Your Injury:	**Time of Your Injury**: ☐ am ☐ pm	**Time You Reported to Work**: ☐ am ☐ pm

What job were you performing at the time of your injury?

Please describe how your injury occurred – give complete details:

Do you feel there was anything that could have been done to prevent your injury? *Safety equipment, training, actions etc.*

What are your injuries and what part(s) of your body are affected? Be very specific in accordance with Missouri Workers' Compensation Statutes Section 287.020 RSMo. Please circle the body part affected.



Please provide the names of anyone who may have witnessed your accident or injury & contact info:

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and true. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a class D felony in accordance with Missouri Workers' Compensation Statutes Section 287.128 RSMo.

_____ _____

Employee's Signature **Date Signed**

_____ _____

Supervisor's Signature **Date Signed**

Retain a copy of this report and give the original to your Supervisor

Supervisor's Incident/Accident Investigation Report

To be completed by the supervisor only - please provide full details where applicable.

Full Name of Employee:	**Name of Supervisor**:	
Employee's Job Title	**Employee's Hire Date**	**Employee's hourly wage**
Did the employee request medical treatment?	**Did the employee complete the Employee Incident/Accident Report?**	
Did the employee return to work?	**Has the injury been reported to the insurance carrier?**	
Employer Address		

Date of Injury:	**Time of Injury**: ☐ am ☐ pm	**Time the Employee Reported to Work**: ☐ am ☐ pm
Job the employee was performing at the time of injury?		
Please describe how the injury occurred – give complete details:		
Do you feel there was anything that could have been done to prevent the injury? Safety equipment, training, actions etc. **Was the employee utilizing any safety equipment? Describe.**		
What injuries, symptoms, and part(s) of body are affected? Be very specific in accordance with Missouri Workers' Compensation Statutes Section 287.020 RSMo.		
Please provide the names of anyone who may have witnessed the accident or injury:		

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and true. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a class D felony in accordance with Missouri Workers' Compensation Statutes Section 287.128 RSMo.

_____ _____

Supervisor's Signature **Date Signed**

Retain a copy of this report