

**JEFFERSON COUNTY
ON-THE-JOB INJURY/ILLNESS REPORT**

EMPLOYEE INFORMATION: (ALL INFORMATION MUST BE COMPLETED)

Employee Name: _____ SS#: _____
Last First M.I.

Date of Birth: _____ Home Phone #: _____ Race: _____

Mailing Address: _____
Street City State/Zip County

Marital Status: Married Widowed Separated Single Divorced # of Dependent Children: _____ Spouses Name: _____

Length of Service: In Current Position: _____ Months _____ Years In Occupation: _____ Months _____ Years

INJURY INFORMATION: (ALL INFORMATION MUST BE COMPLETED)

Date of Injury: _____ Time of Injury: _____ AM PM

Was there any lost time: Yes No Date Lost Time Began: _____

Nature of Injury: Abrasion Amputation Allergic Reaction Bite Break Burn Contus/Bruise
 Concussion Carp.Tun. Syn Contag. Disease Dislocation Dust Elec. Shock Fracture Heart Attack
 Hernia Heat Stroke Inflammation Infection Laceration Poison Puncture Sprain
 Strain Other _____

Body Part Injured: Left Right

Ankle Arm low Arm Upper Back Low Back Upper Back Middle Ear Elbow Eye
 Finger(s) Foot Hand Head Heart Hip Knee Leg Low
 Leg Upper Mouth Neck Pelvis Teeth Thumb Toe Wrist
 Mult Body Parts Other _____

How and Why Injury/Illness Occurred: _____

Did you get any type of medical treatment for your injury? Yes No If yes, have you been taken off of work by the doctor? Yes No

If yes, please give the following Doctor/Facility information where treatment was rendered:

Doctor/Facilities Name: _____

Doctor/Facilities Mailing Address: _____

Was employee doing his regular job? Yes No
Street City State/Zip

Worksite Location of Injury (stairs, side of road, office, etc): _____

Cause of Injury: Animal/Insect Assault/Criminal Burn/Chemical Burn/Fire Burn/Hot Obj Burn/Misc.
 Cut/Glass Cut/Hand Tool Cut/Power Tool Cut/Misc. Fall/Same Lvl Fall/Diff. Lvl Fall/Ladder
 Fall/Misc. Foreign Body Eye Slipped Step/Object Strain/Carry Strain/Hold Strain/Jumping
 Strain/Lifting Strain/Misc Strain/Pulling Strain/Push Strain/Misc. Struck/Object Vehicle Collision
 Other _____

Name of Business if incident occurred on a business site: _____

Address where injury occurred: _____
Street City State/Zip County

Witnesses to incident: _____

Return to work date expected: _____ Department: _____

Supervisor's Name: _____ Phone Number: _____

Supervisor's Signature: _____ Date Reported: _____

**RETURN ORIGINAL TO THE RISK MANAGEMENT DEPARTMENT WITHIN 24 HOURS
Fax (409) 835-8634**