



Unified Government Human Resources Guide

Effective 05-01-2019

INJURY REPORT

ATTENTION: The injured employee and their supervisor should fill out the first two pages of this form. Send one copy of this form to Human Resources at workcomp@wycokck.org by *the next business day following the incident* and retain one copy for department files.

Department/Division:		Today's Date:	
Department/Division Contact Person:			Phone:
Employee Name:		Employee Phone:	
Job Title:		Employee ID:	
Employee Schedule: (Mark days worked)	<input type="checkbox"/> Su <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa	Hours:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m. to <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Home Address:		City/State:	Zip:
Date of Injury:	Time:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Date Reported:	Reported to:		
Exact location of accident:		Was this Unified Government property? <input type="checkbox"/> yes <input type="checkbox"/> no	
Describe in detail how the accident happened:			
Substance or object that directly caused injury:			
Describe in detail nature and extent of injury:			

Part of body affected:

- eye(s) head ear(s) nose back arm(s) hand(s) elbow(s) finger(s) leg(s) foot toe(s)
 knee(s) shoulder(s) facial bones ankle(s) other (please specify): _____

Injury type:

- | | | | |
|----------------------------------------------|--------------------------------------|-----------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> amputation | <input type="checkbox"/> concussion | <input type="checkbox"/> foreign object | <input type="checkbox"/> repetitive stress (incl. carpal tunnel) |
| <input type="checkbox"/> bloodborne pathogen | <input type="checkbox"/> contusion | <input type="checkbox"/> fracture | <input type="checkbox"/> skin irritation (incl. poison ivy) |
| <input type="checkbox"/> bite/sting | <input type="checkbox"/> disease | <input type="checkbox"/> laceration | <input type="checkbox"/> sprain/strain |
| <input type="checkbox"/> burn | <input type="checkbox"/> dislocation | <input type="checkbox"/> puncture | <input type="checkbox"/> other (specify) _____ |

Was medical treatment required? yes no If yes, where treated: First Aid Clinic Hospital/ER Other

Describe "other," if checked: _____

Name/address of Clinic/Hospital/ER: _____



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Witnesses: (If more than two, identify on separate page. Please attach witness statements.)

Name: _____ Phone: _____ Employee yes no
Address: _____ City/State: _____ Zip _____
Name: _____ Phone: _____ Employee yes no
Address: _____ City/State: _____ Zip _____

Employee Work Status

Please attach a copy of the employee's work status or doctor notes and return with the completed injury report.

The above employee is:

- | | |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | Working at his/her regular duty (no restrictions). |
| <input type="checkbox"/> | Working at light or modified duty (can provide work within the given restrictions).
If checked, please state location/task provided: |
| <input type="checkbox"/> | Off work because of temporary total disability (no work available within restrictions or employee taken off of work by authorized medical provider).
If checked, please enter date Injury Leave began: |

Employee Signature: _____ Date: _____

Employee Print: _____

Supervisor Signature: _____ Date: _____

Supervisor Print: _____



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SUPERVISOR REVIEW AND ACTION

ATTENTION: Supervisors complete the following section. **Employee:** _____ **DOI:** _____

How was the employee acting when the incident occurred? Select all that apply.

- Apparently normal
- In a hurry/rushing
- Stressed
- Impaired
- Fatigued/Fell asleep
- Frustrated
- Complacent
- Other: _____

Environment

Which environmental conditions played a role in the accident? Select all that apply.

- Inadequate lighting
- Poor housekeeping
- Lack of warning signs or devices
- Unstable terrain
- Noise
- Other: _____
- Weather/Temperature
- Poor visibility
- N/A

Cause of injury

What was the primary cause of the injury?

- Struck against/by
- Caught in/between
- Improper body mechanics/Lifting
- Contact with
- Over exertion
- Repetitive stress injury/Carpal tunnel
- Slip/Trip/ Fall
- Other individual
- Other: _____

Equipment

- Unfamiliar with new equipment
- Defective equipment
- Wrong equipment used
- Unguarded equipment
- Equipment availability
- No equipment involved

Training

Is the employee familiar with the job task and has the employee been trained on how to perform the task?

- Not familiar with task. No training.
- Formal training occurred but forgotten by employee.
- Familiar with task; no formal training in place.
- Formal training but failed to follow proper procedure.

Prevention

What actions are planned to help prevent a reoccurrence of this type of accident?

Supervisor Signature: _____ **Date:** _____

Division Head Signature: _____ **Date:** _____

Received by Human Resources: _____ **Date:** _____