



NON-OCCUPATIONAL INJURY/ILLNESS REPORT

Date of Report: Job Number: Time: AM PM Supervisor:

Employee Name: Badge Number: Last four of Social:

Address: City: State: Zip Code:

Phone Number: Date of Birth: Age:

Employee Craft: Length of time in Craft: How long on this project?

THIS SECTION TO BE COMPLETED BY EMPLOYEE ONLY

NATURE OF NON-OCCUPATIONAL INJURY/ILLNESS

INJURY

- Concussion
- Cut/Puncture
- Bruise
- Dental
- Back/Neck Injury
- Joint Injury (knee, etc)
- Sprain/Strain
- Dislocation
- Fracture
- Motor Vehicle Accident

ILLNESS

- Allergic reaction
- Blood Pressure
- Diabetes
- Fever
- Gastrointestinal
- Heart
- Respiratory
- Seizure
- Cold/Flu
- Dizziness

OTHER

Description of illness/injury not listed:

Treatment:

NONE SELF CARE ONLY MEDICAL TREATMENT

Treatment Provided By:

Date of Incident: Time of Incident: AM PM

What is your chief complaint?

Exact location of Incident:

Was there a specific incident that caused your injury/illness? If so, please explain:

I, am reporting a personal injury or illness and confirm that this injury/illness is NOT related to my job and did not occur at or in relation to my job. I also understand that I may be required to provide a medical release from a qualified healthcare provider and/or participate in the Fitness for Duty process prior to resuming my job.

Employee Signature: Date:

Safety / Medic Signature: Date: