Work-Related Injury Report Form

This form should be completed by a PICS staff member and be submitted to the PICS HR Administrator as soon as possible after an external worker informs PICS of a work-related injury.

Worker's Personal Information

FULL NAME	BIRTH DATE	HIRED DATE
FULL HOME ADDRESS		
PHONE NUMBER	EMAIL	
REPRESENTATIVE NAME	REPRESENTATIVE'S SERVICE COORDINATOR NAME	
EMPLOYMENT TYPE ☐ PART TIME ☐ FULL TIME	GENDER ☐ MALE ☐ FEMALE	

Injury / Accident Information

DATE OF INJURY	TIME OF INJURY	HAS WORKER RETURNED TO WORK? ☐ YES ☐ NO
DID INJURY CAUSE LOSS OF TIME FROM WORK? (if yes, explain details)	PROVIDE NAMES OF ANY WITNESSES TO ACCIDENT / INJURY	
DESCRIBE INJURY: WHAT PARTS OF THE BODY WERE AFFECTED? WHAT TYPE OF INJURY?		
DESCRIBE WHAT THE WORKER WAS DOING AND HOW INJURY OCCURRED:		

Treatment Information

WAS INJURY TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO	TAKEN BY AMBULANCE? ☐ YES ☐ NO
MEDICAL PROVIDER NAME	MEDICAL PROVIDER PHONE NUMBER
DESCRIBE TREATMENT RECEIVED	

PICS Staff Member Name: _____ **Today's Date:** _____

PICS Staff Member Signature: _____

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