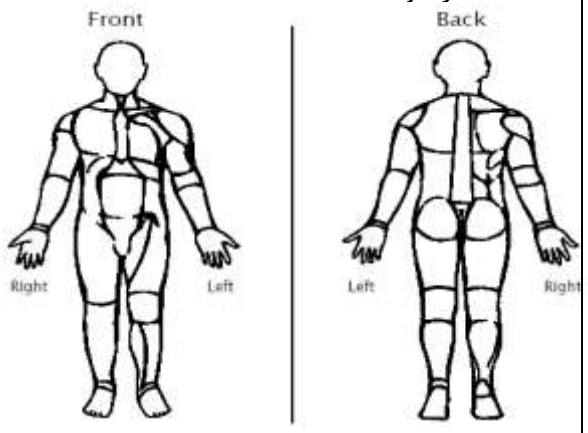
HennepinHealthcare Research Institute

EMPLOYEE INJURY/INCIDENT REPORT FORM

- This form is to be completed for **all job-related injuries or illnesses** – **regardless of extent** – within 24 hours
- The back side of this form must be completed by your supervisor, or their designee, within 48 hours of incident.
- Human Resources needs to receive notification within 72 hours of the incidents in order for timely reporting.

PERSONAL INFORMATION			
Employee's Name		**Address (Street, City, State, Zip)**	
Home Phone Number	**Work Phone Number**	**Social Security Number**	**Date of Birth**
Date of Hire	**Job Title**	**Work Schedule (For example: M-F 8-4:30, M-Th 7-5:30)**	

INJURY/INCIDENT INFORMATION				
Date of Injury	**Time of Injury**	**Date you first Started Missing Work**	**Date Returned to Work**	**Fully Recovered?** ☐ **Yes** ☐ **No**
Explain exactly what happened to you or how your physical illness or injury first started. Please answer as completely as possible and mark the area(s) on body diagram, if applicable.			Circle Areas of Injury Below 	
Was this injury due to: ☐ **Product** ☐ **Procedure** ☐ **Operator Error** ☐ **Not Known**				
Witnesses (Name, Address, phone number, Relationship)				
If you are not fully recovered explain your present condition in detail:				
Date on which you first saw your doctor	**List all Treating Physicians (use another sheet of paper if necessary) (Name, Address, Phone #)**		**Are you still being treated?** ☐ **Yes** ☐ **No**	
Have you ever had this or any other injuries in the past? If yes, please explain (including dates):				
Employee Signature			**Date**	

PLEASE RETURN THIS FORM TO YOUR SUPERVISOR

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SUPERVISOR'S INJURY/INCIDENT REPORT

(TO BE COMPLETED BY THE SUPERVISOR AFTER DISCUSSING THE INCIDENT WITH THE EMPLOYEE)

EMPLOYMENT INFORMATION		
Employee's Name:	**Employee's Job Title:**	**Department/Division:**

INJURY/INCIDENT INFORMATION				
Date of Injury	**Time of Injury**	**Date First Started Missing Work**	**Date Returned to Work**	**Date Injury Reported to You**

Did the incident occur on employer's premises? ☐ **Yes** ☐ **No**	**Exact location of Incident**	**Did you witness this incident?** ☐ **Yes** ☐ **No**	**Estimated duration on restricted work duty**

What was the employee doing when injured? Please be specific.
How did the incident occur? (Be specific: what object(s), circumstances or person directly caused the incident.)
Was this injury due to: ☐ **Product** ☐ **Procedure** ☐ **Operator Error** ☐ **Not Known**
Witnesses (Name, Address, phone number, Relationship)
What action will be taken to avoid a reoccurrence?
Do you have any reason to doubt the validity of this claim? ☐ **Yes** ☐ **No** **If yes, explain:**
Have there been similar injuries in the past? ☐ **Yes** ☐ **No** **If yes, explain**:

Supervisors Signature	**Date**	**Work phone number**
2ND Level Supervisor Signature	**Date**	**Work phone number**

PLEASE RETURN THIS FORM ASAP TO HUMAN RESOURCES, PP4.430