

## EMPLOYEE'S REPORT OF INJURY/ILLNESS

\*Complete within 24 hours of injury and fax to CoStaff at 248.671.0802\*

Employee Name		Social Security Number	
Employee Address, City, State, Zip			
Employee Phone		Date of Birth	
Date of Injury		Time of Injury	
Location of Injury		Time Began Work	<input type="checkbox"/> AM <input type="checkbox"/> PM
Work-Site Employer Name			

Mark areas of injury below.



Front



Back

CAUSE	TYPE OF INJURY
<input type="checkbox"/> Slip and fall	<input type="checkbox"/> Scrape / Bruise
<input type="checkbox"/> Struck by equipment	<input type="checkbox"/> Sprain / Strain
<input type="checkbox"/> Lifting or moving	<input type="checkbox"/> Puncture wound
<input type="checkbox"/> Caught (in, on or between)	<input type="checkbox"/> Cut / Laceration
<input type="checkbox"/> Needle puncture	<input type="checkbox"/> Concussion
<input type="checkbox"/> Object in eye ( <input type="checkbox"/> Left <input type="checkbox"/> Right)	<input type="checkbox"/> Bite
<input type="checkbox"/> Repetitive / Overuse	<input type="checkbox"/> Chemical Burn/Rash/Breathing Issues
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
_____	_____
_____	_____
_____	_____

Describe details of the injury and how it occurred.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was the injury reported to your work-site employer?  Yes  No

If yes, what date was it reported to work-site employer? \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

Did you report to:  Clinic  Hospital  Refused medical attention.

If applicable, indicate name of Clinic/Hospital: \_\_\_\_\_

Last day worked \_\_\_\_\_

Have you gone back to work?  Yes  No If yes, date of return \_\_\_\_\_

Name of witnesses to injury: \_\_\_\_\_

I understand that making false or fraudulent statements for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_