EMPLOYEE INJURY REPORT - CITY OF CANTON
REPORT ALL ACCIDENTS WITHIN 24 HOURS - - HOWEVER SLIGHT!

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This form must be completed in its entirety and sent **IMMEDIATELY** to the **Department of Human Resources**

INJURED EMPLOYEES NAME:			SS#:
HOME ADDRESS:		CITY/STATE/ZIP:	PHONE:
DATE OF BIRTH:	AGE:	( ) MALE ( ) FEMALE	MARTIAL STATUS:

JOB TITLE:	DEPT.:	LENGTH OF EMPLOYMENT:
DATE & TIME OF ACCIDENT:	WERE YOU ON CITY TIME? ( ) Yes ( ) No	
DATE & TIME REPORTED TO SUPERVISOR:	TO WHOM REPORTED?	
LOCATION OF ACCIDENT **(ADDRESS)**:		
WAS THE ACCIDENT ON CITY PROPERTY? ( ) Yes ( ) No	DATE OF REPORT?	
IF MORE THAN (24 HOURS) ELAPSED BETWEEN ACCIDENT & THIS REPORT, STATE REASON FOR DELAY:		

DESCRIBE ACCIDENT: IN DETAIL, DESCRIBE THE EVENTS WHICH RESULTED IN THE INJURY.

WHAT WERE YOU DOING? ____

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IF YOU WERE LIFTING AN OBJECT, STATE APPROXIMATE SIZE, WEIGHT & DISTANCE LIFTED. IF YOU SLIPPED OR FELL, WHAT CAUSED IT? ETC. ____

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GIVE EXACT NATURE OF INJURIES (amputation, laceration, fracture, bruises, etc.) **& EXACT PARTS OF BODY AFFECTED** (first joint of left index finger, right lower leg, lower right side of back, etc.) ____________________

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NAME & ADDRESS OF PHYSICIAN AND/OR HOSPITAL RENDERING TREATMENT FOR THIS INJURY:

(HOSPITAL REPORT SHOULD BE ATTACHED)

____ TREATMENT DATE ______________

FAILURE TO ANSWER EACH QUESTION FULLY MAY DELAY PROCESSING OF ANY CLAIM

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CERTIFICATION

Under penalties of falsification, I, the undersigned, have examined this report and hereby certify that the information is true and correct to the best of my knowledge and belief.

____ Date Signed: __________________

Signature of Injured Employee

RELEASE OF MEDICAL RECORDS AND INFORMATION

I expressly waive all provisions of law which forbid any person(s) or medical facility who heretofore did or who hereafter may medically attend, treat or examine me or may have information of any kind relative to this incident, from disclosing such knowledge or information to the representative(s) or the City of Canton.

I understand that this information may be used in Workers' Compensation claim evaluation or review.

____ Date Signed: __________________

Signature of Injured Employee