FIRST REPORT OF INJURY/ILLNESS FORM -- TOWNSHIP OF JACKSON
(800) 293-9795

☐ FOR RECORD ONLY/NO MEDICAL ATTENTION REQUESTED

☐ MEDICAL ATTENTION REQUESTED BY EMPLOYEE
APPT DATE & TIME: ____________ ☐ SENT TO ER: _________

EMPLOYEE SECTION (PART I)

Last Name: ______________________ First Name: ______________________ Social Security Number: ______ - _____ - _______

Home Address: ____

Home Phone: ( ) _________________ Work Phone: ( ) _____________ Cell: ( ) _______________________

DOB: ______________ Marital Status: ☐ S ☐ M ☐ D ☐ W Sex: ☐ M ☐ F

Job Title: ______________________ Dept: ______________________ Date of Hire: _______________

Employment Status: ☐ Full Time ☐ Part Time _______ (Less than 30) ☐ Seasonal Work Schedule: _____________
Circle One: (35/40)

Date of Injury: _____________ Time of Injury: ____________ ☐ AM or ☐ PM

When this accident was first reported? ______________________________________

Give the exact location where the accident occurred: ____ Zip Code: ______________

Description of the Injury and how it happened: (Note part of body injured include right or left):
____
____

Please list names of any witnesses: __________________________________ Witness Contact #: ____________________

Employee Signature: ____ Date: __________________________

SUPERVISOR SECTION (PART II)

Supervisors Name: _______________________________________ Supervisor Title: _____________________________

Supervisor Contact Phone Number: ( ) __________________

1. Did you supervise this Employee on the date of the accident? ☐ YES ☐ NO
2. Was the accident immediately reported? ☐ YES ☐ NO
3. Was the Employee working alone or with others? ☐ ALONE ☐ WITH CREW
4. Was the Employee at work and on Company Time? ☐ YES ☐ NO
5. Did you physically inspect the area where the injury occurred? ☐ YES ☐ NO
   (If yes, please describe the area) ____
   ____
6. Any unsafe conditions/unusual Hazards present? ☐ YES ☐ NO
7. Evidence of Horseplay? ☐ YES ☐ NO Evidence of Drug Abuse ☐ YES ☐ NO
8. Evidence of Intoxication? ☐ YES ☐ NO
9. Was safety equipment provided? ☐ YES ☐ NO
10. If so, describe the safety equipment: ____
11. Was safety equipment in use? ☐ YES ☐ NO
12. Was immediate medical attention necessary? ☐ YES ☐ NO
13. Are you satisfied that the accident/injury occurred as described above? ☐ YES ☐ NO
14. Describe actions taken to prevent reoccurrences: ____
    ____

Supervisor Signature: ____ Date: __________________________ *(07/2019)*