LEE COUNTY
SOUTHWEST FLORIDA

EMPLOYEE INJURY/ILLNESS REPORT FOR WORKERS' COMPENSATION

(PURPOSE TO REPORT AN ON-THE-JOB INJURY/ILLNESS & PREVENT FUTURE REOCCURRENCE)

The Report of Injury/Illness must be submitted to Employee Health Coordinator (Fax 239-485-2094); Risk (Fax 888-242-3233); and respective department Safety Coordinator within 24 hours of injury/illness. If the employee is unable to complete his/her account of the incident, the supervisor will provide the information, in addition to the analysis of the cause of injury.

EMPLOYEE'S ACCOUNT OF THE ACCIDENT

Employee's Name:		**Social Security #**	**DOB:**
Home Address:			
Home Phone:	**Work Phone:**		**Alternate Phone:**
Job Title:		**Date of Hire:**	**Hourly Pay Rate:**
Department:	**Date of Accident:**	**Time of Accident**	**Location and city/town of accident**
		_____ ☐AM ☐PM	

In your own words, explain in detail, what you were doing immediately prior to the incident and then how you believe the Injury happened:

Employee's Signature:	**Date:**

SUPERVISOR'S ANALYSIS OF THE ACCIDENT

Date Employee reported injury Was Employee offered medical treatment? ☐ Yes ☐ No

Did employee seek medical treatment? ☐ Yes ☐ No

If employee sought medical treatment, name of facility_____

Did Employee lose time from work (other than for medical treatment)? ☐ Yes ☐ No

If yes, date last worked: _____

Nature of injury and part of body involved (e.g. cut left hand, strained back, bruised leg, etc.):

Name and telephone number of the witnesses to the accident:

1.

2.

Do you concur with the Employee's account of the accident? ☐Yes ☐ No ☐ Unsure

If you answer no or unsure, please explain:

What factors caused the injury?

Describe actions taken or needed to prevent reoccurrence:

Supervisor (Print Name):	Date:
Supervisor's Signature:	Work or Alternate Phone No.: ( )

DEPARTMENT DIRECTOR REVIEW

☐ Investigation Sufficient ☐ Suggested additional actions on reverse ☐ Report to be submitted to Safety Committee

Department Director Signature:	Date: