



INJURY AND ILLNESS REPORT

Name (Last, First MI)			Date of Birth			MM	DD	YY	
			Month /Day/ Year						
Address (Complete permanent address)			Date of Accident		MM	DD	YY	Time of Accident	
			Month /Day/ Year						
			Medical treatment required?						
			First Aid treatment only?						
Exact location where accident took place (inside, outside, building name, room #, vehicle, etc.)									
Describe the activity engaged in at the time of the accident (Explain in detail)									
Nature of Injury or Illness									
Have you been treated for a similar injury or condition in the past? Yes ___ No ___									
If Yes, Dates of treatment, Name of Doctor, Hospital or Clinic providing treatment.									
Part of body injured (check ALL that apply, and circle appropriate position)(Thumb=Finger 1, Great Toe=Toe 1)									
<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	Back U M L	<input type="checkbox"/>	Finger R L 1 2 3 4 5	<input type="checkbox"/>	Head	<input type="checkbox"/>	Mouth
<input type="checkbox"/>	Ankle R L	<input type="checkbox"/>	Eye R L	<input type="checkbox"/>	Foot R L	<input type="checkbox"/>	Knee R L	<input type="checkbox"/>	Neck
<input type="checkbox"/>	Arm R L	<input type="checkbox"/>	Elbow R L	<input type="checkbox"/>	Hand R L	<input type="checkbox"/>	Leg R L	<input type="checkbox"/>	Nose
<input type="checkbox"/>	Wrist R L	<input type="checkbox"/>	Shoulder R L	<input type="checkbox"/>	Toe R L 1 2 3 4 5	<input type="checkbox"/>	Other:		
Witnesses: NAME			Address			Phone Number			
Report Date		MM	DD	YY	Work Phone	Home Phone		Officers Activity Report #	
Month /Day/ Year									
Injured / Ill Party									
Sign:									
Reporting Officer									
Sign:									

Fill out then print and sign.

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