TOWN OF VERNON

EMPLOYEE INJURY REPORTING FORM

Today's Date: _____

Date of Incident:	**Time of Incident:**	**Time Workday Began:**
Incident Address:		
Incident Reporter Name:		**Phone:**

Injured Person's Name:		**DOB:**	**□ M □ F**
Home Address:		**Marital status: □ S □ M □ D □ W**	
City:	**State:**	**ZIP:**	
Home Phone:	**Work Phone:**		
Job Title:	**Work Status: □ FT □ PT □ TEMP □ VOL FIRE**		
Supervisor Name:		**Phone:**	
To whom did you report the incident?			
Specific location at address where incident took place:			
Treated by Employer: □ YES □ NO	**Went to Urgent Care: □ YES ☑ NO**	**Refused Medical Attention: □ YES □ NO**	
Other Medical Provider: □ YES □ NO	**Name/Address:**		

Describe bodily injury sustained including specific affected body parts (i.e. left/right, inner/outer, etc.):

Describe how the incident occurred including events leading up to the incident (i.e. what you saw or heard):

On-site treatment received:
List all equipment, materials, and/or chemicals you were using when incident or exposure occurred:
Were safeguards or safety equipment provided □ YES □ NO □ N/A **If provided, were they used? □ YES □ NO**
Witness to the incident? □ YES □ NO If yes, please list name(s): **(Witness should complete an Accident/Incident Witness Form.)**
Do you have a pre-existing injury to the affected area(s)? □ YES □ NO **If yes, describe previous injury including date:**

Injured Person's Signature:	**Date:**

ALL INJURIES SHOULD BE REPORTED WITHIN 24 HOURS OF ACCIDENT/ INCIDENT. Please fax to Town Administration at 860-870-3580 or email to: dwoodruff@vernon-ct.gov.

SUPERVISOR USE ONLY: **HR USE ONLY:**

CIRMA Ref. #			**Work Restrictions?**	**□ YES □ NO**
Date Claim Entered			**Restrictions Accommodated?**	**□ YES □ NO**
Social Security #			**Lost time from work?**	**□ YES □ NO**
Date of Hire			**Return to Work Date**	