Wayne County Employee Report of Accident / Injury

The employee must complete this report as soon as possible following the accident / injury and forwarded to the supervisor within 24 hours.

Personal Information

Name		Date of Injury		Time	
Social Security #		Date of Birth		Dept #	
Home Address					

Injury Information

Describe the circumstances causing the injury.

Have you had a Previous or Similar Injury to this area before? ☐ Yes ☐ No If yes, explain.

Work Status

Medical Only	☐					
Restrictions	☐	From:		To:	Total Days	
Lost Time	☐	From:		To:	Total Days	

Treatment & Facility ☐ **No Treatment** ☐ **First Aid** ☐ **Outside Medical Treatment**

☐ MedPro ☐ NOW Clinic ☐ Emergency Room ☐ Other

Witness Signature _____ Date _____

Witness Signature _____ Date _____

Employee Signature _____ Date _____

Supervisor Signature _____ Date _____