Rowan County Employee Report of Injury / Illness Report

Employee must complete this report as soon as possible and return it to their supervisor for a work related injury or illness. Once complete the supervisor must submit the report to the Risk Manager no later than 24 hours of the incident.

NAME: _____ Date of Injury/Illness: _____

Time of Injury/Illness: _____ AM PM SSN# _____ DOB: _____

Home Phone: _____ Work /Cell Phone: _____ FT ☐ PT ☐

Home Address: _____

Start Time of Work: _____ AM / PM

Witnesses (attach statement of each witness)

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Exact location Injury / Illness occurred: _____

Describe the circumstances causing the injury:

Duties being performed: _____

Personal Protective Equipment Used:
Foot Protection ☐ Face/Eye Protection ☐ Fall Protection ☐ Respiratory Protection ☐
Hand Protection ☐ Head Protection ☐ Apron/Chaps ☐ Back Belt ☐ None ☐
Lifting Assistance Device ☐ Other ☐
Object, equipment, or substance, which caused injury: _____

Choose factor(s), which directly or indirectly caused the accident to occur:
☐ Struck by Flying/Thrown Object ☐ Caught in/Under/Between Objects ☐ Temperature Extremes
☐ A Fall ☐ Struck by an Object/Person ☐ Rubbed or Abraded by Object ☐ Bodily Reaction ☐ Electric Shock
☐ Struck Against Object ☐ Blood/Fluid Exposure ☐ Vehicle/Equipment Accident ☐ Other ☐

Body Part Injured: _____

Employee's Signature: _____ Date: _____
Supervisor's Signature: _____ Date: _____