Washington County Workers' Compensation Employee Incident Report

This form is to be filled out by the employee. The original is to be given to the Finance Office and a copy is to be given to the Supervisor within 24 hours of the incident. Please attach copies of all doctor's notes or forms.

Name
Address
Phone Number
Date of Birth
Social Security #
Male or Female

Position title
Department
Work address
Work phone
Supervisor
Supervisor phone
Date of Hire
Wages per hour
Wages per week
Hours per week

Date of injury
Time of injury
Location of incident
Address of incident

Describe fully how injury occurred and what employee was doing when injured.

List all injuries and specify body part(s) involved. (ex. right hand or left hand)

Any missed work? If yes, how many days?
Treated by a physician? If yes, name of physician.
Name of clinic/hospital
Address of clinic/hospital
Phone of clinic/hospital
Date and time seen by a physician
Did you go to the Emergency Room?
Name and phone number of any witnesses to your injury

Employee Signature_____ **Supervisor Signature**_____
Todays Date_____