Employee Injury Report Form

***Report all injuries as soon as possible to*:**
Human Resources, Skyhawks Sports Academy, Inc.
Scan and email to skyhawks@skyhawks.com or FAX: 509.466.6906

Employee Information

Employee Name: ______________________ SSN: ______________
Address: ____
(Street, City, State, Zip)
Home Phone: ______________________ Date of Birth: ______________
Job Title / Duties: ______________________ Gender: ☐ Male ☐ Female
Supervisor's Name: ______________________ Phone Number: ______________

Accident / Injury Information

Date of Injury: __________ Time: ______ am/pm Date Reported: __________
Location (Where accident occurred): ______________________________
Description of Accident: ______________________________
____
____
Witnesses: (Include name and phone number) ______________________
____
Part of the Body Injured: ______________________________
(i.e. head, right arm, left leg)
Nature of the Injury: ______________________________
(i.e. fracture, cut, sprain)

Treatment

☐ First Aid: ______________________ 1st Day of Treatment ______________
(Type of first aid administered)
☐ Hospital / Clinic: ______________________________
(Hospital Name & Address)
Treatment: ______________________________
Length of Stay: ______________ 1st Day of Treatment: ______________
☐ Physician: ______________________________
(Practice Name & Address)
Treatment: ______________________________
1st Day of Treatment: ______________________________

Time Loss

Did employee lose time from work? ☐ Yes ☐ No If yes; date returned to work: ______________
Was employee paid for date of injury? ☐ Yes ☐ No
Employees Regular Work Hours: ______ hours/day ______________ days/week
Employment Status: ☐ Full Time ☐ Part Time ☐ Seasonal

Employee's Signature: ______________________ Date: ______________

Supervisor's Signature: ______________________ Date: ______________