

**DIOCESE OF CHARLESTON
EMPLOYEE REPORT OF INJURY ON THE JOB**

Name: _____

Address: _____

Phone: _____

Soc. Sec. #: _____

Date of birth: _____

Marital status: Single/Divorced

Date of hire: _____

Married

Job title: _____

Separated

Pay rate: _____ per hour/day/week/month

Number of dependents: _____

Days worked/week: _____

Date of injury: _____

Time of injury: _____

Time began work: _____

AM / PM

AM / PM

Location where accident occurred: _____

Part of body affected: _____

(Be specific: left, right, upper, lower, etc.)

How injury or illness/abnormal health condition occurred (be specific on the activity and work process you were engaged in as well as the sequence of events): _____

All equipment, materials, or chemicals I was using when accident or illness exposure occurred:

Safeguards and/or safety equipment used: _____

Witness' name: _____

Witness' phone number: _____

I am requesting medical treatment.

I do not wish to seek medical treatment.

Signature of employee

Date