REDFORD UNION SCHOOLS
OCCUPATIONAL INJURY REPORT

Please fill out this form completely when reporting a work-related injury or illness

EMPLOYEE DATA

LAST NAME	FIRST NAME, M.I.	S.S. NUMBER	D.O.B.
STREET ADDRESS		CITY	ZIP
TELEPHONE NUMBER	JOB TITLE	GROUP	

INJURY DATA

DATE OF INJURY	TIME OF INJURY	DATE INJURY REPORTED	INJURY REPORTED TO/BY (NAME)
DID YOU STOP WORK AS A RESULT OF YOUR INJURY? IF YES, WHEN?		WHAT PART(s) OF YOUR BODY WERE INJURED? (INCLUDE LEFT OR RIGHT)	
DESCRIBE FULLY HOW INJURY HAPPENED			
WITNESS NAME(s)			
EMPLOYEE'S SIGNATURE/DATE			

I HAVE BEEN OFFERED MEDICAL TREATMENT FOR MY WORK-RELATED INJURY/ILLNESS AND VOLUNTARILY DECLINED

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EMPLOYEE'S SIGNATURE DATE