



INJURY AND ILLNESS REPORT FORM

Environmental Health & Safety

Employee Name: _____

Date of Injury: _____

Time Injury Occurred: _____

Department: _____

Job Title: _____

Contact #: _____

Employee's Start Time: _____

Home Address: _____

City/State/Zip Code: _____

Birth Date: _____

Hire Date: _____

Specific Location of Incident (bldg, floor, room #, inside/outside): _____

Injured Body Part: Face/Neck Head Eyes Legs Hands Back Arms Feet
 Respiratory Other, specify _____

Type of Injury/Illness: _____

Describe how Injury/Illness Occurred: _____

Describe Contributing Factors/Events (Describe events preceding the Injury/Illness): _____

Witnesses/Others: _____

Contact #: _____

Supervisor: _____

Contact #: _____

Does Employee Need Medical Treatment? YES NO

I agree with the information above.

Employee Signature: _____

Date: _____

Supervisor Signature: _____

Date: _____

Name of Treating _____

Facility: Physician's _____

Phone #: _____

Name: Address: _____

City/State/Zip Code: _____

Please Fax Completed Form to EHS General Safety Office: (404) 894-5042
If Medical Attention was given, Supervisors Must Notify: DOAS 24 Hour Injury Report Line - (877) 656-7475