REPORT OF INJURY OR ILLNESS

TURNER & ASSOCIATES insurance

Location	State	Dept	Phone
Employee Name	DOB	Employee #	
Address	City	State	Zip
SS#	Married ☐ Yes ☐ No	Sex ☐ Male ☐ Female	
Job Title	Hire Date		

Description of Incident:

Release of Medical Information: *I certify that the above information is true to the best of my knowledge and I authorize the release to my employer and workers' compensation company all records relevant to my disability and my claim for disability or workers' compensation benefits, including but not limited to medical diagnosis, prognosis, treatment, and periods of hospitalization. It is understood that the company will use the information to verify my disability and determine my eligibility of appropriate benefits. This authorization applies to physicians and other health care providers, hospitals, clinics, insurance companies, workers' compensation carriers, and organizations administering benefit programs. This authorization will remain in effect throughout my claim for workers' compensation benefits. I understand that I have the right to revoke this authorization in writing. A photocopy of this authorization will be as valid as the original.*

Employee Signature:	**Date:**

Incident Details

Date of Incident	Time of Incident	☐ AM	☐ PM	Date Reported
Incident Location (area)	On Employer Premise	☐ Yes	☐ No	
Witness(es)				
Employee lost time to injury	☐ Yes ☐ No	First Aid Given	☐ Yes	☐ No
Date Worker Left Work	Time Worker Left Work	Date Worker Returned		
Medical Facility	Doctor			
Follow Up Appointment Scheduled		☐ Yes	☐ No	
Time Off Authorized by Physician	☐ Yes ☐ No	If Yes, How Many Days		
Treatment Given	☐ Prescription	☐ Irrigation	☐ Sutures	☐ Tetanus Shot
	☐ Brace	☐ Cast	☐ Remove Foreign	☐ None
☐ Ace Bandage	☐ Other:			

Part of Body Injured									
☐ Head		☐ Arm	R L	☐ Trunk	R L	☐ Hip	R L	☐ Foot	R L
☐ Face		☐ Elbow	R L	☐ Shoulder	R L	☐ Thigh	R L	☐ Toe	R L
☐ Eye	R L	☐ Forearm	R L	☐ Chest	R L	☐ Knee	R L	☐ Ribs	R L
☐ Nose		☐ Hand	R L	☐ Back	R L	☐ Leg	R L	☐ Skin	R L
☐ Neck		☐ Finger	R L	☐ Abdomen	R L	☐ Ankle	R L	☐ Other	R L
Other:									

Nature of Injury (mark all that apply)				
☐ Abrasion	☐ Puncture	☐ Chemical	☐ Inhalation	☐ Burn
☐ Bruise-Crushed	☐ Fracture	☐ Hearing	☐ Fatality	☐ Other
☐ Laceration	☐ Poisoning	☐ Sprain	☐ Heat/Cold	☐
☐ Amputation	☐ Dermatitis	☐ Strain	☐ Foreign Object	☐
Other:				

Investigation Supervisor			
Date of Investigation		Investigator Name	
Employee's Supervisor		Supervisor's Phone	
Who was immediately in charge at time of injury?			
Employee task trained?	☐ Yes ☐ No	Yes, explain:	
Equipment Involved	Type	Model	Mfg.

Cause of Injury – (mark all that apply)				
☐ Body Motions	☐ Hot/Cold	☐ Flame/Smoke	☐ Ladders	☐ Slip/Trip/Fall
☐ Bldg/Structure	☐ Conveyors	☐ Furniture	☐ Machines	☐ Flying Object
☐ Chemicals	☐ Electrical –HV	☐ Hand Tool	☐ Notices	☐ Flash
☐ Vehicles	☐ Electrical - LV	☐ Hoisting	☐ Particles	☐ Other
☐ Falling Objects				
Other:				

Cause of Incident – (mark all that apply)				
☐ Equipment	☐ Material Handling	☐ Excessive Speed	☐ Poor Housekeeping	☐ Horseplay
☐ Lack of Attention	☐ Slippery Surface	☐ Procedure Failure	☐ Fatigue	☐ Other
Other:				

Analysis
Description of Incident:

Steps Taken to Prevent Similar Occurrence	
☐ Reinstruction of Employee	☐ Formal Disciplinary Action
☐ Reminder Instruction to All Employees	☐ Installation of Guard Device
☐ Personal Protective Equipment Required	☐ Counseling of Employee
Explain:	

Supervisor Signature:	**Date:**

Send report to: **D. Jarrett Bridges**
Turner & Associates
Phone (912) 265-2840 ♦ Fax (912) 265-2976