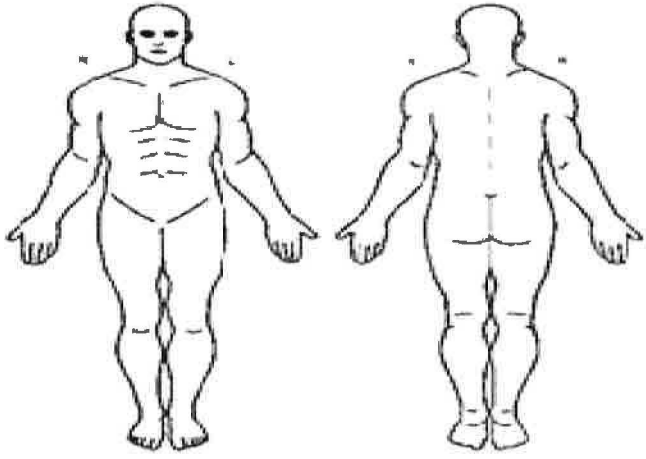


Occupational Injury or Illness **Employee** Report

It should be completed soon as possible to obtain the most accurate information.

Employee Name: _____		Employer: _____		
Explanation of injury (How, When, Where)				
Date you first noticed the pain?		Did this pain develop gradually?	Or suddenly?	
If the pain developed suddenly, exactly what were you doing when the pain was felt?				
If nothing unusual or unexpected happened, what do you think caused the pain?				
List body parts injured: _____				
Have you discussed this pain with anyone at work? If yes, with whom and when? Yes No				
Have you had any recent non-work-related injuries/illnesses? If yes, please list: Yes No				
If the above answer is yes, what was the problem, when did it occur, and what (if any) medical treatment did you receive?				
Show part(s) of the body injured, noting the longevity, type and degree of pain.				
On the diagram below, indicate the location, description, and level of pain you are experiencing at this time. Example: "A-6= Ache- Severe pain"				
		Note type of pain:		
		A = Ache	B = Burning	P = Pins & Needles
		N = Numbness	S = Stabbing	O = Other
		Note level of pain:		
		0	No Pain	
		1	Mild pain, you are aware of it, but it doesn't bother	
		2	Moderate pain that requires medication to tolerate the	
		3	More severe pain	
		4	Severe pain	
		5	Intensely severe pain	
6	Most severe pain, unbearable			
		Was medical treatment away from the job site offered?		
		Yes No		
If treatment was offered, but declined, please sign: _____				
Have you ever received medical treatment for the injured body part(s) listed above? If so, please note the date and physician/hospital where treatment was rendered.			Yes No	
I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief they are correct and complete.				
Employee Name (Print): _____		Date of Birth: _____		
Employee Signature: _____		Date: _____		