SCC Cleaning Company Inc.

Personal Injury Report

Date: ______________________ Time: _____________ ☐ A.M ☐ P.M.

Account Name ____ Account Number ___________

Employee Name ____

Address ____

City ___________________________________ State __________ Zip ________________

How did the injury occur: (describe in detail the activities of the employee when the injury occurred and parts of body affected)

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Where did injury occur: ____

Date of injury: ______________________ Time of injury: ________________ ☐ A.M. ☐ P.M.

Who was injury reported to: ____

Was any treatment necessary? ☐ Yes ☐ No

If yes, what treatment?

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Did employee refuse treatment? ☐ Yes ☐ No

Did employee go to hospital? ☐ Yes ☐ No

If yes, what hospital? ____

Was any time off work needed? ☐ Yes ☐ No

If yes, how many hours? ____

____ ______________________

Employee Signature Date

____ ______________________

Supervisor Signature Date

FAX TO CORPORATE OFFICE IMMEDIATELY (847) 360-9077