

LOCK HAVEN UNIVERSITY OF PENNSYLVANIA WORK-RELATED INJURY REPORT

DATE OF INJURY

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

<input type="text"/>	<input type="text"/>	<input type="text"/>
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DATE OF BIRTH

JOB TITLE

<input type="text"/>	<input type="text"/>
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TIME EMPLOYEE BEGAN WORK

TIME OF OCCURRENCE

<input type="text"/>	<input type="text"/>
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TYPE OF INJURY OR ILLNESS (EX; STRAIN, SPRAIN, CONTUSION, LACERATION)

PARTS OF BODY AFFECTED

HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?

WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?

YES NO

YES NO

WITNESS FIRST NAME

WITNESS LAST NAME

WITNESS PHONE NUMBER

<input type="text"/>	<input type="text"/>	<input type="text"/>
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PREPARED BY