



ON-THE-JOB INJURY REPORT

TO REPORT A CLAIM TO SEDGWICK, CALL **1-877-576-1911**

CLAIM NO: _____

Employee Information

Last Name: _____ First Name: _____ MI: _____ SSN: _____
Address: _____ City: _____ STATE: _____ Zip: _____ PH: _____
DOI: _____ TIME: _____ LOCATION OF INJURY: _____ DOB: _____ DOE: _____
Division: _____ DEPT: _____ BUREAU #: _____ SAL: _____
FULL-TIME: ___ PART TIME: ___ TEMP: ___ NEW INJ: ___ OLD INJ: ___ OLD INJ DATE: _____
NOTICE ONLY: _____ HOURS WORKED: _____ DAYS OFF: _____ SUPERVISOR: _____
OCCUP: _____ HOSPITAL/DOCTOR: _____
SHIFT COMPLETED: YES _____ NO _____ DRUG SCREEN: YES ___ NO _____

Type of injury/Body Parts

- HEAD SCALP FACE EYE(S) EARS (S) MOUTH
 NECK THROAT SHOULDER(S) UPPER ARM ELBOWS FOREARM
 WRIST HANDS(S) FINGER(S) BACK CHEST RIBS
 HIPS UPPER LEG KNEE(S) LOWER LEG ANKLE FOOT
 TOE(S) BODY SYSTEM (HHL OR ILLNESS)
 MISC. PARTS _____ INDICATE: LEFT RIGHT

Injury Classification

- HEART LUNG HYPERTENSION STRAINS/SPRAINS ABRAS/BRUISES
 FRACTURE CUTS PUNCTURES ANIMAL/INSECT BITES RASH
 BURNS HEAT INJURY COLD INJURY RESPIRATORY (INHALATION)

Treatment of Injury

- NO TREATMENT FIRST AID/STAYED ON DUTY TREATED HOSP/RTN TO DUTY
 TREATED HOSP/PUT OFF TREATED HOSP/ADMITTED OTHER TREATMENT

Injury Occurred Due To

- LIFTING STRUCK AGAINST STRUCK BY SLIP/TRIP FALL
- CAUGHT IN/UNDER/BETWEEN PULLING PUSHING INSPECTING
- EQUIPMENT HANDLING IMPROPER LIFTING LIFTING HEAVY OBJECT
- MOTOR VEHICLE ACCIDENT FOREIGN MATTER (EYE/SKIN) PICKING UP GARBAGE
- OTHER _____

Personal Protection Equipment Used

- HELMET (HARD HAT) COAT TURNOUT PANTS TURNOUT BOOTS TYVEK SUIT
- SHOES (SAFETY) GLOVES LATEX GLOVES SAFETY GOGGLES NOMEX HOOD
- SAFETY VEST LADDER BELT (HOOKED) ELECTRICAL GLOVES

SCBA (MASK) USED: YES NO SEAT BELTS FASTENED: YES NO

OTHER PROTECTIVE EQUIPMENT USED: _____

DESCRIPTION OF HOW INJURY OCCURRED/OTHER REMARKS: _____

I certify that the above information is true to the best of my knowledge: (I hereby authorize the Release of Medical Information and Treatment for this on-the-job injury.)

Signature of Injured Employee Date Completed Supervisor/Commanding Off. Date Rec.

OSHA Coordinator Date Received TIME LOST NO TIME LOST DEATH