

CITY OF SAINT PAUL

EMPLOYEE'S SAFETY REPORT

INJURY OR AGGRAVATION

EMPLOYEE MUST SUBMIT THIS REPORT WITHIN 24 HOURS OF WORK-RELATED INJURY OR AGGRAVATION.

DEPARTMENT _____ DIVISION _____ ACTIVITY CODE _____

- 1 Name of injured employee _____ Phone: Home _____ Work _____
2 Home address (including city and zip code) _____
3 Date of Birth _____ Male Female Marital status _____ Soc. Sec. # _____
4 Job title _____ Salary \$ _____ Hourly Biweekly
5 Job Status Full time Part time Temporary Do you have another job? No Yes
6 If YES, provide company name, your position and salary: _____

INJURY INFORMATION

- 7 Date injured _____ Time _____ Date reported to supervisor _____ Was time lost from work? No Yes
First day lost (date) _____ Return to work, actual or expected (date) _____
8 Was medical treatment given? No Yes Provide name and address of physician and/or hospital: _____
9 Nature of injury (cut, sprain, burn, etc.) _____
10 Part/parts of body injured _____
11 Exact location of accident _____
12 Describe accident in detail _____
13 If aggravation, what caused resumption of symptoms? _____
14 Did you have a prior injury to this portion of the body? No Yes When?
Did prior injury or disability contribute to this injury? No Yes Explain?
15 Witnesses (names and phone numbers) _____

I certify that all statements in this report are true. _____ (Employee Signature) Date _____

Supervisor's comments: _____

Supervisor's signature: _____