QCI Healthcare

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Kalamazoo Office
5955 West Main
Kalamazoo, MI 49009
Phone: 616-365-9290
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Injury Report Form

EMPLOYEE INFORMATION

Name: _____ SS#: _____

Job Title: _____ Department: _____

INCIDENT INFORMATION

Date/Time of Incident: _____ Location: _____

Date/Time Injury Reported: _____ Reported To: _____

Description of Incident: _____

_____

INJURY INFORMATION

Description of Injury(s): _____

_____

Recorded on OSHA 200 Form? ❑ YES ❑ NO | Est. Days of Disability: _____

TREATMENT INFORMATION

Was the employee treated on company premises? ❑ YES ❑ NO

If yes, describe treatment: _____

Did the employee return to work with modifications to their duties? ❑ YES ❑ NO

If Yes, describe modifications: _____

Was the employee sent home? ❑ YES ❑ NO | Return to work date: _____

Was the employee sent to the hospital? ❑ YES ❑ NO | Return to work date: _____

Describe hospital treatment: _____

_____

INJURY REPORT

Prepared by (print)_____

Signature _____ Date: _____