



This injury report should be filled out by the employee and signed by both the supervisor and employee. Please call the Benefits/Injury Management Office at **780-5175**, and report the injury immediately. If medical attention is needed, call **Bayside Employee Health** at **780-6631**. This form should be faxed to Benefits/Injury Management at **780-5199**, and the original mailed to the McLellan House, Gorham, ME, 04038.

Name: _____ SS #: _____ Home Phone #: _____

Home Address: _____
Street City State Zip

Sex: **M / F** Date of Birth: _____ Time your work day began: _____ **am / pm**
Month/Day/Year

Title: _____ Department: _____ Work Phone: _____

Date of Injury: _____ Time of Day: _____ **am / pm** Date reported to Supervisor: _____
Month/Day/Year Month/Day/Year

Did anyone witness this accident? Yes / No Who? _____

Did the incident occur on employer's premises? Yes / No Where? _____

Are you employed elsewhere? Yes / No Where? _____

Explain how the injury occurred and activity employee was doing at the time of injury:

Identify all parts of body affected: _____

Have you ever had a similar problem in the past? If so, explain: _____

When did you first think that work was causing this problem? _____

Employee, please complete second page and sign. Thank you!

Supervisor (Please Complete)

Payroll Acct. Number to be charged for injury expenses on this employee: _____

Did employee leave work on the day of this injury? **Yes / No** When did they leave? _____ **am / pm**

Did employee lose time from work due to this injury? **Yes / No** What time did they lose? _____

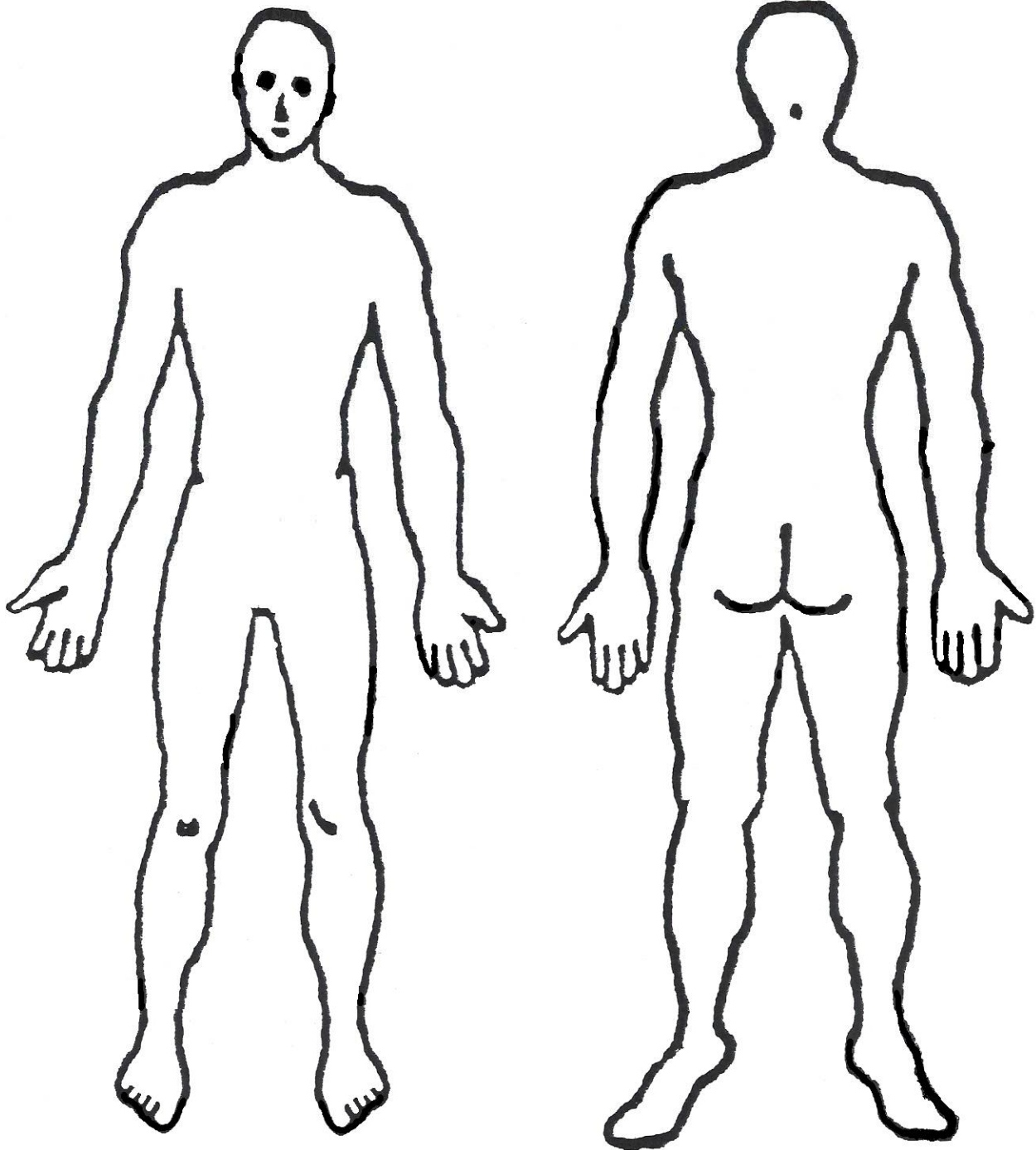
Did you refer the employee for medical evaluation? **Yes / No** Appt. Date: _____ Time: _____

Immediately notify the Injury Management Office? Date: _____ Time: _____ **am / pm**

Please review this form, make sure the employee completes the back, sign it and fax immediately to 780-5199. Please mail the original to Injury Management, McLellan House, Gorham, ME, 04038.

Supervisor Signature

PLEASE SHADE IN ALL AREAS
AFFECTED BY YOUR INJURY



Date: _____

Employee Signature: _____

Print Name: _____