

## Worker Information

Organization	_____	Pers ID	_____	Emp. Type	_____
Employee's Name	_____	DOB	_____	Ethnicity	_____
Job Title	_____	Gender	_____	Phone	_____
Home Street	_____	Hire Date	_____	Supervisor	_____
City	_____	State	_____	Zip	_____

## Work Assignment Information

On DNR Premises?	_____	Job Title at Injury	_____	Time on Job	_____
Event Location	_____				
Date Reported	_____	To Whom	_____	Witness	_____

## Injury Information

JSA Reviewed: \_\_\_\_\_

Date of Injury	_____	Time of Injury	_____	IIR #	_____
Nature of Injury	_____		<input type="checkbox"/> Sudden Event	<input type="checkbox"/> Symptoms developed over time	
Body Part	_____	<input type="checkbox"/> L <input type="checkbox"/> R	Event or Exposure	_____	
Injury Description	_____				
<input type="checkbox"/> Medical Evaluation	Evaluation Date	_____	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Hospitalized as In-Patient	
Medical Provider	_____				
	Clinic Name & Address:	_____			

## Incident Information

<input type="checkbox"/> Medical Only	<input type="checkbox"/> Restricted Duty	<input type="checkbox"/> Time Loss
Unsafe Condition	Unsafe Act	
Why did the unsafe condition exist?	Why was the unsafe act committed?	
_____		
Description of Event		
_____		
Apparent Causes:		
_____		
Root Causes:		
_____		
Corrective Actions	Who will correct	Est. completion date
_____	_____	_____