



## Livingston County Employee's Report of Injury

Full Name of Injured Employee \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_ Date of Hire \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Married or Single \_\_\_\_\_ Department \_\_\_\_\_

Names / Ages of Dependent Children

\_\_\_\_\_  
\_\_\_\_\_

Which of the above dependent children are at least 50% supported by you?

\_\_\_\_\_

Occupation when injured \_\_\_\_\_ Name of Supervisor \_\_\_\_\_

Were you doing your regular work? \_\_\_\_\_ If not, what work \_\_\_\_\_

Exact location where injury occurred \_\_\_\_\_

Date of Injury \_\_\_\_\_ Hour of the day \_\_\_\_\_ am \_\_\_\_\_ pm \_\_\_\_\_

Witnesses' Names \_\_\_\_\_

Describe fully how injury occurred \_\_\_\_\_

\_\_\_\_\_

Continue on back if necessary

What part of your head, limbs or body was hurt \_\_\_\_\_

Describe your symptoms: \_\_\_\_\_

Attending Physician and Address \_\_\_\_\_

No. of treatments to date: \_\_\_\_\_

Names and addresses of any other doctors seen \_\_\_\_\_

Are you still receiving medical treatment? \_\_\_\_\_ From whom? \_\_\_\_\_

Did you lose time from work? \_\_\_\_\_ If so, what was your last day worked? \_\_\_\_\_

If you have returned to work, what was the date? \_\_\_\_\_ If not, when do you expect to return \_\_\_\_\_

To whom was this injury reported \_\_\_\_\_ On what date \_\_\_\_\_ Time \_\_\_\_\_ am  
pm

Employee's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

If medical attention is necessary, your employer will furnish treatment subject to the provisions of the Worker's Compensation Act

