

EMPLOYEE INCIDENT/INJURY REPORT

THIS REPORT TO BE COMPLETED BY INJURED EMPLOYEE.

NAME: _____

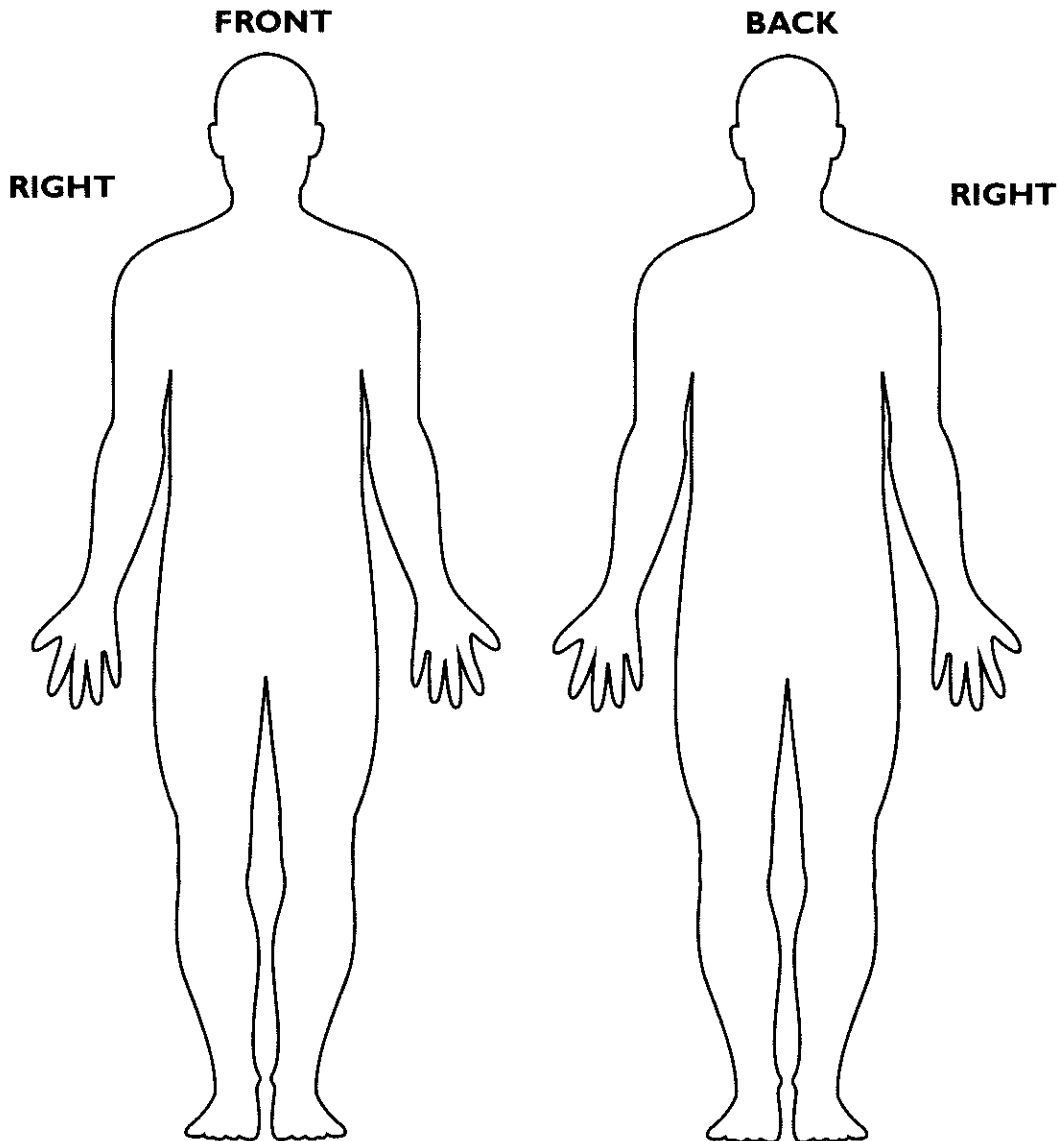
DATE: _____

DEPARTMENT: _____

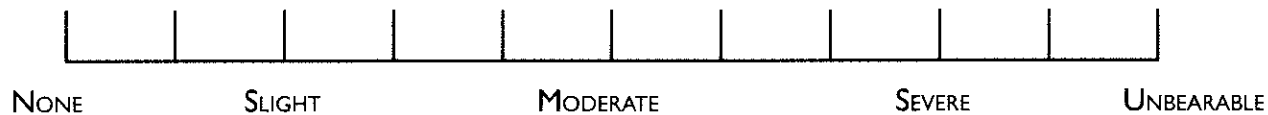
JOB: _____

MARK THE AREAS OF THE BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS WITH THE APPROPRIATE SYMBOLS FROM THE CHART BELOW.

NUMBNESS	+++++	SHARP	/////
BURNING	xxxxx	DULL & ACHING	*****
PINS & NEEDLES	00000	WEAKNESS	▽▽▽▽▽



Indicate Pain Level Below



SIGNATURE: _____ DATE: _____

WITNESS: _____ TITLE: _____ DATE: _____