REPORT OF MINOR INJURY

SECTION #1

EMPLOYEE NAME: _____ DEPT.# _____

EMPLOYEE JOB TITLE: _____

WHEN EMPLOYEE CAME FOR TREATMENT. DATE: _____ TIME: _____ A.M. P.M.

DATE OF INJURY: _____ TIME: _____ A.M. P.M.

IS TREATMENT NECESSARY? (IF SO, STATE NATURE OF INJURY AND INCLUDE EMPLOYEE'S STATEMENT.)

_____

_____

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_____

TREATMENT ADMINISTERED: _____

_____

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_____

_____

EMPLOYEE SENT: WORK___ HOME___ DOCTOR_____ HOSPITAL_____
(IF SENT TO DOCTOR OR HOSPITAL, INDICATE NAME.)

EMPLOYEE SIGNATURE: _____

FIRST AIDER SIGNATURE: _____

COPY TO LEAD TECH/ALLIED SUPERVISOR

SECTION #2

LEAD TECH/ALLIED SUPERVISOR

LEAD TECH/ALLIED SUPERVISOR REMARKS & CORRECTIVE ACTION: _____

_____

_____

_____

_____

LEAD TECH/ALLIED SUPERVISOR SIGNATURE: _____

SECTION #3

AREA MANAGER

AREA MANAGER REMARKS: _____

_____

_____

_____

_____

AREA MANAGER SIGNATURE: _____ CTL019882

RETURN TO SAFETY DEPARTMENT

JSS-063 5-11-87