ESSG Incident / Injury Report Form

PERSON REPORTING TO COMPLETE THIS FORM ASAP AFTER INJURY—FAX TO ESSG AT 952.835.1255

Personal and Incident Details (Circle and/or complete responses)

Last Name:		First and Other Names:
Date of Birth:		Length of time on this assignment:
Sex: M / F	Social Security #:	Assigned at:
Phone: (Home):		Phone: (Message):
Date of incident:		Time of incident: : am/pm
How did the incident occur?		
Name(s) of witness:		Phone:

Supervisor Notification

Name of Supervisor:	Date and time notified: _____/_____/_____ : am/pm

INJURY DETAILS

Description of Injury(s):
____
____
____

Part(s) of the body affected: ____

Date and time when symptoms/injury noticed: _______/_____/_____ : am / pm

Taken to Hospital / Clinic Yes:_____ / No:_____

If Yes:
Name and Address of Hospital / Clinic where taken for treatment:

Address:____
____

Phone:______________________

Signed:	Print Name:	Phone:
Position:		Date: / /