CALM

Occupational Injury or Illness Report

This form contains sections to be completed by employee and/or supervisor.

The accident should be investigated by the supervisor of the injured employee or department involved. It should be completed soon as possible to obtain the most accurate information.

Employee Section

Date of Injury:		Date Reported:		Employer Name:	
Name of Employee:			S.S. No:	XXX-XX- (last four digits)	
Home Address, City, Zip Code:					
Employee Email Address:		Work Ext:		Date of Birth:	
Cell Phone:					
Sex:	Occupational Title:		Employee's Department/Division:		
Time Work Shift Began: AM/PM		Time Accident Occurred: AM/PM		Day of week M T W TH F S SU	
Location:					

Injury Type (Circle)

25	Foreign Body in Eye	**81**	Animal, Insect, Human Bite	**28**	Fracture
43	Cut/Puncture	**46**	Hernia/ Rupture	**02**	Amputation
40	Abrasion/Scratches	**99**	Heart Attack/Stroke	**68**	Skin Irritation/ Dermatitis
10	Bruise/Contusion/Crushing	**72**	Hearing Impairment	**07**	Concussion/ Loss of Consciousness
49	Sprain/Strain	**66**	Exposure (Chem. Temp. Elect)	**24**	Death
04	Burn (Chem, Liquid, Electrical)	**81**	Exposure (Blood/ Body Fluid)	**00**	Other

Injury Cause (Circle)

46	Struck by/ Against Object	**31**	Noise	**85**	Animal, Insect, Human
25	Fall-Same Level, Different Level	**98**	Repetitive Motion/Trauma	**84**	Hot Object, Substance or Fire
54	Jumping or Climbing	**30**	Slipping/Tripping	**26**	Caught in/Under/ Between
48	Vehicle Accident/ Struck by Vehicle	**57**	Pushing/Pulling/ Lifting/ Carrying	**59**	Other

Was injury caused by another person, faulty/broken equipment, a vehicle?	Yes	No	
If yes, explain:			

Body Part Injured (Circle)

02	Head/Neck/Face/Mouth	**44**	Wrist (Left Right)	**74**	Hips/ Buttocks
05	Eye (Left Right)	**45**	Hand (Left Right)	**46**	Fingers (Left Right) Digit:
04	Ear (Left Right)	**61**	Back (Upper Lower)	**83**	Knee (Left Right)
48	Shoulder (Left Right)	**67**	Chest/Abdomen Including internal organs	**85**	Ankle (Left Right)
41	Arm (Left Right)	**66**	Pelvis/ Groin	**86**	Foot (Left Right)
42	Elbow (Left Right)	**82**	Leg (Thigh Calf)	**87**	Toes (Left Right) Digit:
73	Respiratory	**01**	Other	**96**	No Physical Injury

First Aid or Medical Treatment

Was first aid given?	Yes	No	If yes, by whom:	
Was medical treatment required by a physician or hospital?	Yes	No		
Physician/ Hospital Name, Address, and telephone number:				

Employee's Statement

Explanation of injury (How, When, Where)

Date you first noticed the pain?		Did this pain develop gradually?		Or suddenly?	

If the pain developed suddenly, exactly what were you doing when the pain was felt?

If nothing unusual or unexpected happened, what do you think caused the pain?

List body parts injured:

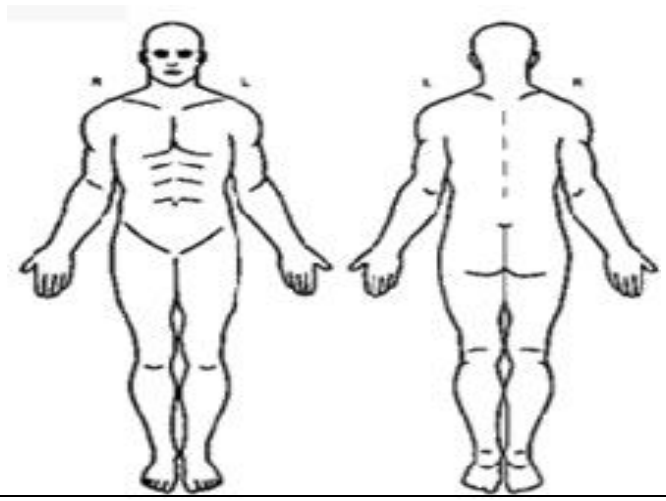
Have you discussed this pain with anyone at work? If yes, with whom and when? Yes No

Have you had any recent non-work related injuries/illnesses? If yes, please list: Yes No

If the above answer is yes, what was the problem, when did it occur, and what (if any) medical treatment did you receive?

Show part(s) of the body injured, noting the longevity, type and degree of pain.

On the diagram below, indicate the location, description, and level of pain you are experiencing at this time.
Example: **"A-6= Ache- Severe pain"**



Note type of pain:

A = Ache	**B** =Burning	**P** = Pins & Needles
N = Numbness	**S** = Stabbing	**O** = Other

Note level of pain:

0	No Pain
1	Mild pain, you are aware of it, but it doesn't bother you
2	Moderate pain that requires medication to tolerate the pain
3	More severe pain
4	Severe pain
5	Intensely severe pain
6	Most sever pain, unbearable

Was medical treatment away from the job site offered?

Yes No

If treatment was offered, but declined, please sign:

Have you ever received medical treatment for the injured body part(s) listed above? If so, please note the date and physician/hospital where treatment was rendered.	Yes	No	
Are you currently receiving Social Security **Disability** Payments (*not Social Security retirement payments*)?	Yes	No	
Are you currently receiving Medicare assistance?	Yes	No	
Do you currently have a Child Support Lien	Yes	No	

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief they are correct and complete.

Employee Name: (Print)	
Employee Signature:	Date:

Supervisor's Statement (ONLY required if employee seeks medical treatment)

As a result of your investigation, what do you believe occurred and why?

From your investigation is the validity of the accident in doubt?	Yes	No	If yes, explain why.

Was a third party at fault? If yes, explain

Were there any witnesses? If yes, please list

Name	**Address**	**Phone**	**Date**

Supervisor's Signature:		**Date:**	