MEMBER INJURY REPORT FORM

Date of incident:_____ Time:_____ AM/PM

Location (circle one): WWO NB SG MEM Other:_____

Name of injured person:_____

Address:_____

Phone number(s):_____

Date of birth:_____ Male_____ Female_____

Type of injury: _____

Details of incident:

_____

_____

_____

Injury require physician/hospital visit? Yes_____ No_____

Name of physician/hospital:_____

Address:_____

Physician/hospital phone number:_____

Person completing form:_____

Forward this form to VP of Branch Operations within 24 hours of incident.

(Employee injuries should be reported to the CAO or Benefits Administrator.)