WORKER'S COMP EMPLOYEE INJURY REPORT

Any work-related injury to an employee received during work hours must be documented by using this form. Fill out the following form immediately. If you are not capable of doing this yourself, it is your responsibility to have someone else assist you. Submit the report as soon as you are capable of doing so by email to HR@GormanUSA.com or fax to 608-835-6220. Contact Gorman & Company's Human Resource Department at 608-835-5788.

EMPLOYEE INFORMATION					
Employee Name		Date of Injury			
Home Address					
Phone Number		Marital Status		Gender	
Social Security #		Date of Birth			
Job Title		Date of Hire			
Days Worked per Week		Average Hours Worked per Week			
Name of Property		Time of Injury	AM / PM		
Property Address					
Date Employer Notified		County			

DESCRIPTION OF INJURY			
What were your activities when the injury occurred? What tools, machinery, objects, chemicals, etc. were involved?			
What happened to cause this injury? Describe how the injury occurred in detail.			
What was the injury? State the part of the body affected and how it was affected. Be specific. (Left/Right)			
Name(s) of Witnesses			
Last Day Worked		Any Missed Shifts From Work? ☐ Yes ☐ No	
Estimated Date of Return to Work			

MEDICAL TREATMENT * If you seek medical treatment of any kind, a return-to-work note is required.*	
Did you seek medical treatment? ☐ Yes ☐ No	Were you treated in an emergency room? ☐ Yes ☐ No
What is the name and address of the treating practitioner?	

Signature: _____ **Date:** _____