GEORGIA DEPARTMENT OF DEFENSE STATE PERSONNEL OFFICE

Workers' Compensation Employee's Report of Injury

To Be Completed by Employee Only

Name of Employee: _____ **Date of Birth:** _____/_____/_____

Home Address: _____ **Home Phone #:** _____

City: _____ **State:** _____ **Zip Code:**_____

Job Title: _____ **Work Location:** _____

Date of Accident: _____**Time of Accident:** _____

Location of Accident:_____

Address/Name of Building **Area (loading dock, bathroom, etc.)**

Describe fully how accident occurred: (Including events that occurred immediately before the accident)

_____

_____

_____

_____

Describe bodily injury sustained (be specific about body part(s) affected):

_____

_____

_____

Recommendation on how to prevent this accident from recurring:_____

_____

_____

Name of Supervisor: _____**Phone #:** _____

Name(s) of Witness(es): _____**Phone #:** _____

(Attach witness(es) report(s)

To whom did you report the injury? _____

When did you report the accident to your supervisor? _____

Do you require medical attention? **Yes:** _____ **No:** _____ **Maybe:** _____

Name of your treating physician: _____**Phone #:** _____

_____ _____

Signature of Employee **Date**