CITY OF GRAND HAVEN

OCCUPATIONAL INJURY/ILLNESS REPORT

Employee Information

Name: ___________________________ Job Title: ___________________________

Department: ______________________ Shift Start Time: ______________________

Incident Information

Date/Time of Incident: _______________ Reported to: _______________________

Date/Time Injury Reported: _______________ On Employer Premises? □ Yes □ No

Address Where Injury Occurred: ____________________________________________

Were proper work procedures being followed? □ Yes □ No - Provide explanation on back of form

Description of Incident (If exposure, also include the Exposure Worksheet):

Body Part(s) Injured: _______________________________________________________

Treatment Information

Was the employee asked if they wanted to seek medical treatment? □ Yes □ No

Did the employee seek medical treatment? □ Yes □ No

If yes, was the employee treated: □ On-site □ Workplace Health □ NOCH □ Other: _________

Following treatment, the employee returned to work: □ Same Day □ Next Shift □ Other: _______________________

Preventable measures recommended addressing the underlying cause of accident:

By signing below, you attest to have completed this report thoroughly and accurately to the best of your knowledge.

_________________________ ___________________________ _______________________
Supervisor’s Signature Supervisor’s Name (Print) Date

_________________________ _______________________
Employee’s Signature Date