EMPLOYEE INCIDENT REPORT

Complete within 24 hours of injury and send to:
POPULAR STAFFING, division of the Chi Group of Companies, Ltd.
5025 E. Main St., Ste. B, Columbus, OH 43213 FAX: 614-759-9378

PART I. EMPLOYEE INCIDENT REPORT

Employee's Name:______________________________ Social Security Number
Home Address:____Age__________
Sex: Male______Female______Occupation__
Accident Location________________________________Department_____________________
Date of Injury__________________Time________am______pm Last Day worked__________
To whom was injury reported? ____
Describe what happened (be specific about *how the accident happened - name any objects or substances involved)*: ____

____

Part(s) of body injured: ____

Name(s) of witness(es): ____
Witness Telephone Numbers (s)____
Was any medical or emergency treatment necessary? Yes______No______
If so, state name of physician and/or hospital:______________________________________
Is this an aggravation of a previous injury? Yes______No ______
Have you ever had a similar injury? Yes______No ______

By signing this form I expressly waive all provisions of law which forbid any person or persons who heretofore did or who hereafter may medically attend, treat or examine me or who may have information of any kind which may be used to render a decision in my claim of injury/disease of____________, 20__ from disclosing such knowledge to my employer. A copy of this form will serve as the original. I understand that a positive result on my post-accident drug/alcohol screen may result in the denial of any Worker's Compensation benefits.

Employee Signature:___________________________________Date_____________________
Printed Name: __________________________________

PART II. SUPERVISOR'S REPORT

Supervisor Signature:__________________________________Date_____________________
Printed Name: __________________________________

Notes: ____

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{IN ADDITION TO PAGE 1 THIS SECTION IS TO BE COMPLETED AND SIGNED BY THE INJURED EMPLOYEE WHEN A BACK INJURY IS REPORTED)

Employee's Name:____

Name of Employer:____

1. What part of your back hurts now? ______________________________________
2. When did you first notice the back pain (date and time)?_________________________
3. What did you feel? ____
4. What were you doing at that time (explain in detail)____________________________

____

5. What type of lift were you performing? (Example: To assist/lift a wheelchair) _______

____

6. Time employed at present job? ____
7. Number of lifts performed per shift?____
8. Have you ever been trained on proper lift techniques?___________________________
9. If you were lifting an object, what was it and how heavy was it?___________________

____

10. What was the exact position of your body when pain was first noticed? ___________

____

11. Have you ever had a back injury before? If so, when? _________________
    Were you treated by a doctor? what part of your back? _______________
    Has it given you further trouble? _____________________________________
12. Have you ever received or filed for compensation because of a back injury?_________
    Other injury? If so, list Bureau of Worker's Compensation claim number (s):

____

The above statements have been made by me and are true and correct o the best of my knowledge.

By signing this form I expressly waive all provisions of law which forbid any person or persons who heretofore did or who hereafter may medically attend, treat, or examine me or who may have information of any kind which may be used to render a decision in my claim of injury/disease of____________, 20__ from disclosing such knowledge to my employer. A copy of this form will serve as the original. I understand that a positive result on my post-accident drug/alcohol screen may result in the denial of any Worker's Compensation benefits.

Employee Signature:___________________________________Date_____________________

Printed Name: __________________________________

Witness Signature:____________________________________Date____________________

Printed Name: __________________________________