METS Employee Incident/Injury Report

- Please print clearly and complete all sections of the Injury Report.
- Please Fax to 517-647-7572 or scan and e-mail to hrdept@contractbusdrivers.com

Employee Information:

Employee Name: ____

Last First Middle

Date of Birth: _________________________ Date of Hire: _______________________________

____

Home Street Address Apt#/PO Box City State Zip

____________________________________ ____________________________________

Cell Phone (include area code) Secondary Phone (include area code)

E-Mail Address: ____

Position Working at time of injury: ____________________ District Assigned to: ____________________________

On Site Supervisor Name, if applicable: ____

Injury Information:

Date of Incident: _____________ Time of Incident: _______ a.m./p.m. (circle one) Date Reported to District: __________________

Employee's Scheduled Shift: (start time) ________ a.m./p.m. (circle one) (end time) _________ a.m./p.m. (circle one)

Name of Location Where Incident Occurred: ____

____

Address Where Incident Occurred City State Zip

What was employee doing when incident occurred? (Be specific) ____

____

____

Nature of Injury (strain, cut, bruise, etc.): ____

Body Part(s) Affected: ____

What object/substance directly harmed the employee? ____

____

Additional Information:

Was there an unsafe condition that contributed to the injury? (circle one): yes no If yes, please specify conditions:

____

What could have been done to prevent this injury? ____

____

Were proper procedures being followed when incident occurred? (circle one) yes no If no, explain: ________

____

If a slip/fall injury, please describe what type of shoes employee was wearing at time of injury?

____

Witnesses: (please list any witnesses to the injury/incident)

____

Print Full Name Contact Phone Number (include area code)

____

Print Full Name Contact Phone Number (include area code)

Medical Treatment Information:

Medical Treatment Required? ______ None at this time ________ First Aid Only _______ Doctor or Hospital

*Medical treatment is not a requirement at time of injury, yet is available if needed. Contact METS HR if you desire more information on treatment options.

Location that treatment was sought at: ____

(name of location)

____

(address of location) (phone number)

Employee Signature:

I hereby declare that the facts stated above are true. A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

____

Employee Signature Date

If an employee receives medical treatment from a doctor or hospital, additional forms/information may need to be filled out/provided for a Workers Compensation claim to be filed.