



Available Staffing Network

Unit 7
 500 Broad Street
 Providence, RI 02907
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Injury Report

General Information

Name of Organization/Workplace			
Location			
Address			
Phone Number		Email	
Person Preparing Report		Designation	Phone

Injury Report Information

Date of Injury		Time/Hours	
Affected person			
When was the Injury reported to the supervisor: Date _____			Time/Hour
Type of Injury		Place where it occurred	

Describe the circumstances that caused the injury			
Describe the activities of the affected person at time of injury			
Any witness		Any medical treatment provided to injured person	
Name the Physician/Hospital			
Address			
Phone		Cost of treatment	
Medical receipts/certificates of physician			
Signature		Date of report submission	
Report Acceptance Information			
Signature of recipient		Designation	
Date		Submit	