INJURY REPORT FORM

Policy Number:		Today's Date

INJURED EMPLOYEE'S INFORMATION

NAME Last, First Middle			Social Security Number	Date of Birth (mm/dd/yy)
Street Address, City, State Zip				County
Phone Number		Sex (Circle One) Male/Female	Marital Status	# of Dependants under 18
Date of Hire	Occupation/Job Title		Employment Status (Full Time,Part Time,Seasonal,Volunteer)	

EMPLOYER INFORMATION

Company Name: Atlantic Film Services		Phone: 973-831-7677
Address: 227 Highland Avenue, Downingtown, PA 19335		County: Chester
Federal Identification Number	Company Contact - First & Last Name	Contact's Phone Number

INJURY OCCURRENCE INFORMATION

Date of Injury	Time Employee Began Work		Time of Occurrence	Full Pay for Day of Injury? *Required*
Last Day Worked	Date Employer Notified		Date Disability Began *(1st full day absent after occurrence)*	
Type of Injury *(contusion, laceration,etc.)*		Cause of Injury *(fall, slip, etc.)*		Parts of Body Affected *(be specific)*
How injury occurred *(Describe sequence of events. BE VERY SPECIFIC. Use additional paper if needed)*				
List ALL Equipment, Materials, Chemicals Involved in Occurrence				Date Employee Returned to Work
Date of Death *(if Fatal)*	Witness - Last, First Name & Phone Number *(Use additional paper if needed.)*			
Was occurrence on Employer premise?			Y / N	
If out of state, specify state where injury occurred:				
Were safeguards/safety equipment provided?			Y / N	
Were safeguards/safety equipment used?			Y / N	
Initial Treatment (None, Emergency Room, Hosipitalized, Employee's Physician, etc.)				
Name & Address of Physician / Healthcare Provider *(if applicable)*				

Injured Employee *(Print)*

Employer *(Print)*

Injured Employee Signature & Date

Employer Signature & Date