WORKFORCE SOLUTIONS TEXOMA
SUBSIDIZED EMPLOYMENT PROGRAM

INJURY INCIDENT REPORT

Worksite Name:____

Worksite Address:____

Complete Information Below about Employee:			
Name:		Sex: ☐ F ☐ M	
SSN:		DOB:	
Complete Information Below about the Incident:			
Date of Injury	Time of Injury	Date Lost Time Began	
Nature of Injury (ex: fall, chemical exposure, etc.):			
Part of Body Injured or Exposed (ex: chin, left upper arm, left forearm):			
Describe in detail the events leading up to the injury/illness, the actual injury, and the reasons why the accident/injury occurred: (Use additional pages if more space is needed.)			
Was employee doing his regular job: ☐ Yes ☐ No		Worksite Injury Location (stairs, dock, office area, etc.):	
Address Where Injury Occurred:			
Cause of injury (fall, tool, machine, hammer, chemicals, etc.):			
Witnesses to Incident:			
Expected Return to Work Date:		Did Employee Die? ☐ Yes ☐ No	
Supervisor's Name:		Date Reported:	
Complete Information Below About Treatment of Injury			
Facility where employee was taken for treatment of Injury:			
Print Name	Signature	Title	Date

Fax Completed Form to: Molina Cheek, Fiscal Officer, 903.957.7413