Employee Injury Report

Name of Injured Employee:

Address:

Telephone:

Occupation: Location of Injury:

Date and Time of Injury:

Date Injury Reported: Time shift started on day of injury: AM PM

Person Reported to:

Witness(es), if any:

Description of Injury:

1. How did this accident occur?

2. What were you doing when you got injured?

3. Object or substance that directly injured you?

4. Describe in detail the nature of the injury and the part of the body affected.

Disability information:

Did you complete your shift on the date of the incident?

Are you disabled or off work? When did you become disabled?

Who treated you (name and address)?

Who referred you to the doctor?

When did you first see your doctor?

Any medical slip?

Employee's Signature:____________________________ Date:_______________

Witness' Signature, if applicable:__________________ Date:_______________

Signature of person reported to:__________________ Date: _______________

ED Signature: _________________________________ Date: _______________

NOTE: HAVE FULL LIFE FILE A WC-1 REPORT USING THE INFORMATION ABOVE

79-7460 Mamalahoa Hwy. Suite 212, Kealakekua HI 96750

(808) 322-9333 (p) (808) 322-9334 (f)

To: Injured Worker

(Please have treating physician complete the information on the following page and return to your supervisor.)

MEDICAL CERTIFICATE REPORT

Injured Worker: ________________________________File Number:_________DOI:_________

Date First Seen:__________Date Last Seen:___________Discharge from Care: Yes:___No:___

1. Current Symptoms:____
____

2. Diagnosis:____Prognosis:____________

3. Is claimant released to work? YES☐ NO☐

Regular Duty Yes:________No:__________Effective Date: ______________

With Restrictions: Yes:_______No:__________Effective Date:_____________

May Perform Work Transitional Duties with the following physical abilities:

____

____

Will claimant be gradually progressed to regular duty? ___________________

Estimated date of release to regular work duty? ________________________

Plan of Care:

a)Therapy:Duration:________________Time Frame:________________

b) Medications:____

d)Diagnostic Testing:MRI____X-ray:_____Other:___________________

e) Surgery:____

Additional Information:____
____

3. Is the patient medically stable? Yes:_______No:_________When:________

4. Estimated date of rating? _________________ No Ratable Impairment Anticipated☐

__________________________________ __________________________

(Provider's Signature) Date

__________________________________ Next Appointment:____________

Provider's Name