

# NON WORK RELATED INJURY REPORT FORM

Employee Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_

Department / Location: \_\_\_\_\_ Supervisor Name: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

## Injury Details:

Describe the injury:

Specific part(s) of body injured:

## Incident Description:

Describe how the injury occurred:

## Witness Information:

Witness Name(s): \_\_\_\_\_

Witness Contact Information: \_\_\_\_\_

## Medical Treatment:

Was medical treatment sought? (Yes/No): \_\_\_\_\_

Name and Address of Medical Provider:

Was employee referred for further medical evaluation? (Yes/No): \_\_\_\_\_

## Employee Statement:

I certify that the information provided in this Non Work Related Injury Report Form is accurate and complete to the best of my knowledge. I understand that this report will be used for processing any applicable benefits and that any falsification or omission of information may result in disciplinary action, including termination, and/or legal consequences.

**Confidentiality Notice:**

This report contains confidential medical and personal information and is intended solely for use by authorized personnel in accordance with applicable United States laws, including HIPAA and ADA provisions. Unauthorized disclosure or misuse of this information is strictly prohibited.

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