CHEROKEE COUNTY
WORKER'S COMP INCIDENT
REPORT FORM

Employee Name ________________________________ Home Phone __________________

Home Address_____________________________________ Cell Phone ________________
(Mailing address, include city)
Number of dependents________ Marital status _______ Date of incident _________________

Time you began work_________ Hours worked per day _____ Days of week worked________

Where did the incident occur?____
(give an exact address if you can)
Time of incident________________________ Supervisor's Name ________________________

Did anyone witness the incident? _______ If so, whom _______________________________

Body part injured (i.e. right knee, left hand, etc)_______________________________________
(be as specific as possible)
Were you using any equipment or tools? ______ If so, what? __________________________

Describe how injury occurred, giving as much detail as possible __________________________

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Time incident reported to supervisor __________ Did you receive medical care? ____________

If medical care received, give provider name? ____

Do you have a follow-up appointment? _______ If so, with whom? ______________________

Date of follow-up appointment ________________

Other than the day of the incident, has any work time been missed? ____ How much ________

This form must be completed within 24 hours of time of injury and returned to the Human Resource Director so the incident can be reported to our Worker's Compensation adjustors. THANK YOU.