

**CHEROKEE COUNTY
WORKER'S COMP INCIDENT
REPORT FORM**

Employee Name _____ Home Phone _____

Home Address _____ Cell Phone _____

Number of dependents _____ Marital status _____ Date of incident _____

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 _____

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.

