ShieldHOTELS

Employee Injury Report

Location:

Carrier Name and Address:

Policy #

Employee: Last Name: First Name:

Employee Address:

Date of Injury:

Time of Injury:

Type of Injury:

All Equipment, materials an/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Date Hired:

Occupation:

Date Disability Began:

Did Injury occur on Employer's premises?
Yes ☐ **No** ☐
Part of Body Affected:

Were Safeguards or Safety Equipment provided:
Yes ☐ **No** ☐
If provided, were they used?
Yes ☐ **No** ☐

Treatment at the Hotel:

Clinic/Hospital Name:

Witness Name:

Witness Signature and Date:

How Injury/Illness occurred: Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill.

Preparer's Name and Title:

Signature: **Date:**

If you need additional space, please turn the form over and write on the back. Send both sides of the page to Shield.