

**Iredell County Employee
Injury/Illness Report Form**

Department _____

Address or Location Where Accident Occurred _____

Employee Full Name _____ aaaaaaaaaaaaaaaaaaaaaa

Employee Address _____
Street City State Zip

DOB _____ Phone Number _____ Date of Hire _____ Male Female

Wages per Hour _____ Number of Hours Worked Per Week _____ Full-time Part-time

Job Title _____ Date of Incident _____ Time of Incident _____ am pm

Time employee reported to work _____ am pm Date employer notified of incident _____

Specific Location of Incident (Ex: Stairs, ladder, auto, etc.) _____

Cause of Incident (describe in detail)

Type of injury received including body part (describe in detail)

Did you seek Medical attention? Yes (attach MD statement) No

Witnesses? If so, give name(s)

Employee Signature and Date _____

Department Head Signature and Date _____