City of MEMPHIS

INJURY REPORT

TO REPORT A CLAIM TO SEDGWICK, **CALL 1-877-576-1911**

CLAIM NO: _____

Employee Information

Last Name:_____First Name:_____MI:_____SSN: _____

Address:_____City:_____STATE:_____Zip:_____PH: _____

DOI:_____TIME:_____LOCATION OF INJURY:_____DOB:_____DOE: _____

Division:_____DEPT: _____ BUREAU #:_____ SAL: _____

FULL-TIME:___PART TIME:____TEMP:_____NEW INJ:_____OLD INJ:_____OLD INJ DATE: _____

NOTICE ONLY:_____HOURS WORKED:_____DAYS OFF:_____SUPERVISOR: _____

OCCUP:_____HOSPITAL/DOCTOR: _____

SHIFT COMPLETED: YES_____NO_____ DRUG SCREEN: YES___NO _____

Type of injury/Body Parts

☐ HEAD ☐ SCALP ☐ FACE ☐ EYE(S) ☐ EARS (S) ☐ MOUTH

☐ NECK ☐ THROAT ☐ SHOULDER(S) ☐ UPPER ARM ☐ ELBOWS ☐ FOREARM

☐ WRIST ☐ HANDS(S) ☐ FINGER(S) ☐ BACK ☐ CHEST ☐ RIBS

☐ HIPS ☐ UPPER LEG ☐ KNEE(S) ☐ LOWER LEG ☐ ANKLE ☐ FOOT

☐ TOE(S) ☐ BODY SYSTEM (HHL OR ILLNESS)

☐ MISC. PARTS_____INDICATE: ☐ LEFT ☐ RIGHT

Injury Classification

☐ HEART ☐ LUNG ☐ HYPERTENSION ☐ STRAINS/SPRAINS ☐ ABRAS/BRUISES

☐ FRACTURE ☐ CUTS ☐ PUNCTURES ☐ ANIMAL/INSECT BITES ☐ RASH

☐ BURNS ☐ HEAT INJURY ☐ COLD INJURY ☐ RESPIRATORY (INHALATION)

Treatment of Injury

☐ NO TREATMENT ☐ FIRST AID/STAYED ON DUTY ☐ TREATED HOSP/RTN TO DUTY

☐ TREATED HOSP/PUT OFF ☐ TREATED HOSP/ADMITTED ☐ OTHER TREATMENT

Injury Occurred Due To

□ LIFTING □ STRUCK AGAINST □ STRCUK BY □ SLIP/TRIP □ FALL

□ CAUGHT IN/UNDER/BETWEEN □ PULLING □ PUSHING □ INSPECTING

□ EQUIPMENT HANDLING □ IMPROPER LIFTING □ LIFTING HEAVY OBJECT

□ MOTOR VEHICLE ACCIDENT □ FOREIGN MATTER (EYE/SKIN) □ PICKING UP GARBAGE
□ OTHER _____

Personal Protection Equipment Used

□ HELMET (HARD HAT) □ COAT □ TURNOUT PANTS □ TURNOUT BOOTS □ TYVEK SUIT

□ SHOES (SAFETY) □ GLOVES □ LATEX GLOVES □SAFETY GOGGLES □ NOMEX HOOD

□ SAFETY VEST □ LADDER BELT (HOOKED) □ ELECTRICAL GLOVES

SCBA (MASK) USED: □ YES □ NO SEAT BELTS FASTENED: □ YES □ NO

□ OTHER PROTECTIVE EQUIPMENT USED: _____

DESCRIPTION OF HOW INJURY OCCURRED/OTHER REMARKS: _____

It is a crime to knowingly provide false, incomplete or misleading information to any party to an on the job injury transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits. Payments are not allowed for injury or claims stemming from, but not limited to falsifications of documents, and / or giving false statements. If you have questions, contact Workplace Safety at 901-636-6459. The Division has a Specialist that can provide assistance. I certify that the above information is true to the best of my knowledge and I hereby authorize the Release of Medical Information and Treatment for this on-the-job injury.

Signature of Injured Employee | Date Completed | Supervisor/Commanding Off. | Date Rec.

□ TIME LOST □ NO TIME LOST □ DEATH

OSHA Coordinator | Date Received

Updated 1/21/2019