PUBLIC SERVICE COMMISSION
FIRST REPORT OF INJURY/ACCIDENT INVESTIGATION
Agency Code: 2700

Date Reported: _____ Time of Call: _____ Person Contacted: _____

Division Information:

Division Employee Works In: _____ Supervisor/Phone#: _____
Address: _____

_____ _____ _____ _____
City State Zip County

Employee Information:

Injured Employees Name: _____ Work Phone #: _____
Home Phone#: _____ Cell Phone #: _____
Address: _____

_____ _____ _____ _____
City State Zip County

Gender: Male ☐ Female ☐

Date of Employment: _____ Title: _____

Injury Report:

Date of Injury: _____ Time of Injury: _____ Salary _____
Hours worked per week: _____ Hours per day: _____ Days per week _____
Location of incident: _____

Investigation of Accident/Incident (include injury that occurred and the cause of accident):

Recommendations: _____

Reviewed By:

Safety Coordinator _____ _____ Workers' Comp. Coordinator _____ _____
Date Date

Forward To:

Immediate Supervisor ☐