



Report the injury immediately. Notify your supervisor and complete this form before the end of your shift.

SECTION 1 – EMPLOYEE INFORMATION -

INJURY DAY & DATE:	INJURY TIME: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> UNSURE
NAME:	JOB: SUPERVISOR:

OFFICE: BAY CITY INDIAN RIVER DETROIT WISCONSIN

1. Was the injury reported to your supervisor the same day? How and When? If not, why?

SECTION 2 – WHERE & WHAT HAPPENED

2. WHERE DID THE INJURY OCCUR? *Be specific on where it happened.*

Customer Site Company Equipment or Vehicle Warehouse (aisle, area, etc.) Other

Details of where the injury occurred:

3. What were you doing at the time of the injury?

SECTION 3 – EMPLOYEE EXPLANATION & INJURY DETAILS

4. Body part(s) affected:

5. Did equipment, product or machinery contribute? No Yes – what?

6. Have you previously had problems with this body part? If yes, explain-

7. Describe exactly what happened, including how the injury occurred. *Include details such as location, equipment used, product involved, route number, aisle number, or client location.*

8. Were there any witnesses? If so, list them- No Yes – explain-



SECTION 4 – MEDICAL TREATMENT - Non-emergency treatment must be approved by HR.

Do not return to work after medical treatment without HR approval.

9. Did you receive or will you receive medical treatment beyond first aid? No, Why? Yes, explain

Were you: Returned to full duty Placed on restricted duty

SECTION 5 – PREVENTION & SAFETY REVIEW

10. What actions, decisions, or behaviors may have contributed to this injury? Explain below.

Work pace Unsafe lifting posture Distraction Fatigue Awareness of surroundings Other

11. Looking back, is there anything you could have done differently to reduce the risk of this injury?

SECTION 6 – RETURN TO WORK ACKNOWLEDGMENT

If you experience a work-related injury or illness, you are required to:

1. Report the injury to your supervisor immediately (no later than the same day) and complete the Injury Report in full.
2. Seek treatment at the company's approved occupational clinic unless emergency care is required.
3. Provide medical documentation of your work status and any restrictions to your supervisor and HR and report any changes within 24 hours.
4. Follow all medical restrictions at all times, both on and off the job. Notify your supervisor or HR immediately if assigned duties conflict with your restrictions.
5. Obtain written HR approval before returning to work—either in person or remotely—while any restrictions are in place. Do not begin working from home or performing any job duties remotely without prior written HR approval.
6. Follow normal attendance procedures, including personally notifying your supervisor of any absence unless otherwise approved in writing, and provide written medical certification for time away from work.
7. Cooperate with return-to-work efforts, including modified or transitional duty when appropriate, and obtain a full-duty release before returning to unrestricted work.
8. Notify HR within 24 hours when released to full duty.

Failure to follow medical restrictions, attendance procedures, or return-to-work requirements may result in disciplinary action.

SECTION 7 – EMPLOYEE ACKNOWLEDGMENT

Incomplete or inaccurate reports will be returned to the employee for completion prior to review.

I confirm the information I've provided about this injury is accurate and complete to the best of my knowledge. I understand and agree to follow the Return-to-Work Responsibilities listed above. I authorize the release of medical information related to this work injury to Fabiano Brothers and its workers' compensation insurance carrier for claim handling, treatment coordination, and return-to-work purposes. This authorization applies only to medical information connected to the injury reported on this form.

X Employee Signature _____ Date: _____ Phone: _____