

# TWFD First Report of Injury

**PRINT CLEARLY**

**This Section To Be Completed By The Injured Employee:**

Injured Employee's Name: \_\_\_\_\_ Rank: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_ AM/PM

Incident location: \_\_\_\_\_

Type of Injury (sprain, cut, etc.): \_\_\_\_\_

Body part(s) involved: \_\_\_\_\_

Medical treatment obtained from: TWFD  MCHD  Clinic/hospital

Name of clinic/hospital if applicable: \_\_\_\_\_

Type of treatment obtained: \_\_\_\_\_

Describe how the injury occur: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Injured Employee: \_\_\_\_\_ Date: \_\_\_\_\_

**This Section To Be Completed By The Injured Employee's Supervisor:**

In your opinion were proper methods being used at the time of the incident: Yes  No

If no, explain: \_\_\_\_\_

\_\_\_\_\_

In your opinion could this accident/injury have been prevented? Yes  No

If yes, how: \_\_\_\_\_

\_\_\_\_\_

In your opinion what corrective actions should be considered to prevent a reoccurrence: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Witnesses:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Supervisor completing this report: \_\_\_\_\_

Signature of Supervisor completing this report: \_\_\_\_\_ Date: \_\_\_\_\_