


|   |   |                |             |
|---|---|----------------|-------------|
|  | <b>EMPLOYEE REPORT OF ILLNESS /<br/>INJURY FORM</b> | Document No.:  | HSE-BF-028  |
|   |   | Department:    | Operations  |
|   |   | Revision Date: | 25 AUG 2010 |
| Release authorized by:  | D. Slattery   | Page           | Page 1 of 1 |

|   |  |          |  |                   |  |
|---|--|----------|--|-------------------|--|
| Employees' Name   |  |          |  |                   |  |
| Job Position/Title  |  |          |  |                   |  |
| Shift Hours   |  | Days Off |  | Supervisor's Name |  |
| Date And Time of Injury   |  |          |  | Location          |  |
| Task Being Performed<br>When Injury Occurred                                    |  |          |  |                   |  |
| Date, Time Injury Reported  |  |          |  | To Whom?          |  |
| Name(s) Of Witness(es)  |  |          |  |                   |  |
| Witness(es) Comments  |  |          |  |                   |  |
| Describe How The Injury Occurred  |  |          |  |                   |  |
| What Part Of The Body Was Injured   |  |          |  |                   |  |
| Describe The Injuries In Detail   |  |          |  |                   |  |
| Date, Time You First Sought Medical Attention                                   |  |          |  |                   |  |
| Name Of Doctor and/or Hospital  |  |          |  |                   |  |
| Could Anything Be Done To Prevent Injuries/Illnesses Of This Type? If So, What? |  |          |  |                   |  |
|   |  |          |  |                   |  |

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date