ON THE JOB INJURY REPORT

CAMBRIDGE
real estate services

Please fill out this form as soon as injured worker is medically stationary or within 24 hours from time of injury.
Once completed, please fax to the Human Resources Department at 503-546-7588. Insure all information is complete and accurate.

NAME (FIRST, MI, LAST)		HOME PHONE
DATE OF BIRTH	SOCIAL SECURITY NUMBER	☐ MALE ☐ FEMALE
MAILING ADDRESS	CITY	STATE ZIP

DATE OF INJURY	TIME OF INJURY ☐ AM ☐ PM	TYPE OF INJURY (STRAIN, CUT, BRUISE, ETC.)	BODY PART AFFECTED ☐ LEFT ☐ RIGHT

ATTENDING PHYSICIAN	PHONE	ADMITTED TO HOSPITAL ☐ YES ☐ NO	NUMBER OF DAYS

NAME & CITY OF MEDICAL FACILITY WHERE TREATED

LOCATION AT TIME OF INJURY (PROPERTY NAME & ADDRESS)

DESCRIBE INCIDENT IN FULL

EQUIPMENT, MATERIALS OR CHEMICALS USED DURING INJURY

WITNESS NAME(S) & PHONE #

DID INJURY RESULT IN TIME LOSS? ☐ YES ☐ NO	DATE LEFT WORK	TIME LEFT WORK ☐ AM ☐ PM

NUMBER DAYS WORKED PER WEEK	NUMBER HOURS WORKED PER SHIFT
WORK SCHEDULE (IE: M-F)	SHIFT SCHEDULE: FROM _____ ☐ AM ☐ PM TO _____ ☐ AM ☐ PM

INJURED ON EMPLOYERS PREMISES? ☐ YES ☐ NO	DURING COURSE OF DUTIES? ☐ YES ☐ NO	DATE RETURNED ON LIGHT DUTY	DATE RETURNED TO REGULAR WORK

WERE OTHER WORKERS INJURED IN THE INCIDENT? ☐ YES ☐ NO	WAS INCIDENT CAUSED BY ANOTHER PERSON OR FAILURE OF MACHINERY OR PRODUCT? ☐ YES ☐ NO

MANAGER COMMENTS

EMPLOYEE SIGNATURE		DATE
MANAGER NAME	SIGNATURE	DATE