GEORGIA TECH
INJURY AND ILLNESS REPORT FORM

☐ **No Medical Attention**
☐ **Medical Attention Required**

EMPLOYEE NAME: **DATE OF INJURY:**

TIME INJURY OCCURRED: ______ am/pm

DEPARTMENT: ______ Job Title: ______

Home Address: ______ Contact Phone #: ______

City: ______ State: ______ Zipcode: ______

Birthdate: ______ Hire Date: ______

Employee's Start Time: ______ am/pm Injured Body Part(s): ______

Location/Building where injury/illness occurred? ______

Description of injury/illness: ______

Describe how injury/illness occurred: ______

Witnesses/Other(s): ______

Supervisor: ______ Supervisor Contact #: ______

Does Employee Need Medical Treatment? **YES** **NO**

I agree with the information above.

Employee Signature: ______ Date: ______

Supervisor Signature: ______ Date: ______

For Medical Use Only

Injury/Illness: ______ Date Treated: ______

Treatment and Comments: ______

Work Instructions:
- ☐ No Restrictions Needed
- ☐ Restrictions Required
- ☐ Lost Time Days

Employee treated in an Emergency Room? **YES** **NO**

Employee hospitalized ? **YES** **NO**

Name of Medical Clinic/Hospital: ______ **Phone:** ______

Physician's Name (print) ______ **Physician's Signature** ______

Address: ______ **City/State/Zip:** ______

If Medical Attention was given supervisors must notify: DOAS 24 Hour Injury Report Line - 877-656-7475