

**NDE REPORT OF ALLEGED OCCUPATIONAL INJURY/ILLNESS**

NOTE: Supervisor and employee should complete and sign. Fill in ALL blanks, indicating NA if the question is not applicable. Be specific.

**Employee:**

- 1. Name \_\_\_\_\_ SS# \_\_\_\_\_
- 2. Home Address (zip) \_\_\_\_\_  
Work Address (zip) \_\_\_\_\_  
Name of Immediate Supervisor \_\_\_\_\_
- 3. Home phone \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_
- 4. Number of children under 18 or incapacitated regardless of age \_\_\_\_\_
- 5. Accident occurred at: (Address, City, County) \_\_\_\_\_  
\_\_\_\_\_
- 6. Describe location where injury/illness took place and conditions which contributed to injury/illness. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 7. How did the accident or injury/illness occur? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 8. What were you actually doing when injured? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 9. Describe injury or illness in detail and indicate the part(s) of the body affected. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 10. Name object or substance which directly injured you. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 11. Scheduled work week at time of injury: Hrs. per day \_\_\_\_ Hrs. per week \_\_\_\_ Days per week \_\_\_\_
- 12. Normal work week: Hrs. per day \_\_\_\_\_ Hrs. per week \_\_\_\_\_ Days per week \_\_\_\_\_
- 13. Date/time of injury or date illness began \_\_\_\_\_ Date/time returned to work \_\_\_\_\_
- 14. Time work day began \_\_\_\_\_ Last full day worked \_\_\_\_\_

15. Name of Department representative who was notified of injury/illness: \_\_\_\_\_ Date: \_\_\_\_\_

16. Individual(s) to be notified in case of emergency.  
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

17. All medical providers consulted regarding injury/illness (update as appropriate):  
Name \_\_\_\_\_ Address \_\_\_\_\_ DATE \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_ DATE \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_ DATE \_\_\_\_\_

18. Witness(es):  
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**NOTE:** If you have received medical attention and expect to lose time from work, return the *Return to Work Recommendation Record* to your supervisor as soon as possible.

\_\_\_\_\_  
Employee's Signature Date

**Supervisor:**

1. Statements from witnesses.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Comments regarding location where injury took place (specifically note any special conditions which contributed to the injury). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Comments regarding injury (specifically note your knowledge regarding any past related injuries or other circumstances that may have contributed to the injury). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This report has been reviewed and is accurate to the best of my knowledge.

\_\_\_\_\_  
Supervisor's Signature Date