EMPLOYEE/VOLUNTEER INJURY/ILLNESS FORM
(OSHA 301 Equivalent Form)

INSTRUCTIONS:

1. Employee/volunteer to complete this form within 48 hours of injury/illness.
2. Obtain the necessary immediate supervisor & director signatures.
3. Forward to HR within 48 hours.

If seeking medical treatment, please advise the health care professional/facility that this is a **work-related** claim. The City is covered under the State of Washington L&I workers compensation program.

EMPLOYEE/VOLUNTEER INFORMATION			
Today's Date:			
Name:	First	Middle	Last
Position Title:		**Department:**	
Home Address:		**Home Phone:**	
City, State, Zip		**Cell Phone:**	
Birth Date		**Female** ☐ **Male** ☐	

INITIAL INJURY/ILLNESS INFORMATION		
Date of injury/illness:		**Time employee began work**:
Time of injury/illness:		
Check one:	☐ Injury/Illness ☐ Fatality	**If fatality, date of death**:
Did injury/illness occur on employer's premises? ☐ Yes ☐ No		
If no, location of injury/illness : *(If exact address unknown, please use place references)*		
Was medical treatment required? ☐ Yes ☐ No Was 911 offered? ☐ Yes ☐ No Was 911 called? ☐ Yes ☐ No		
If yes, please state where treatment received, by whom, & date:		

INITIAL INJURY/ILLNESS INFORMATION (CONTINUED)

What was the employee doing just before the injury/illness occurred? Be specific. Name any tools, equipment or materials that were being used and what the employee was doing with them.

Explain how the injury/illness occurred. List the event(s) that resulted in the injury or illness (what happened & how it happened).

Describe the injury/illness. Indicate body part and how it was affected.

Name the object or substance that directly injured the employee (if applicable).

PHYSICIAN/HEALTH CARE PROFESSIONAL INFORMATION

Name of physician or health care professional:			
Location where treatment was given (if different from worksite):			
Medical facility name:			
Address:		**City, State, Zip**	
Was employee treated in an emergency room? ☐ Yes ☐ No			
Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No			
If yes, length of stay:			
If applicable: # of days away from work: # of days of restricted work activity:			

COMPLETED BY:

Employee Name:

_____ _____

Employee Signature **Date**

THIS SECTION TO BE COMPLETED BY CITY OF MERCER ISLAND EMPLOYEES ONLY!

SUPERVISOR REVIEW

The following supervisor is aware of the incident and has reviewed it with employee completing this form:

_____	_____	_____
Supervisor Name:	Supervisor Signature	Date

The following manager/supervisor have also reviewed this report:

_____	_____	_____
Manager/Supervisor Name:	Manager/Supervisor Signature	Date
_____	_____	_____
Manager/Supervisor Name:	Manager/Supervisor Signature	Date

DIRECTOR REVIEW

The following director has also reviewed this report:

_____	_____	_____
Director Name:	Director Signature	Date

PAYROLL REVIEW

_____	_____
Payroll Signature	Date

_____	_____	_____
Title	Phone #	OSHA Case #

WITNESS STATEMENT

Please attach all witness statements to the Incident Form or Employee/Volunteer Injury/Illness Form

WITNESS INFORMATION			
City Employee?	☐ Yes ☐ No	**If Yes, Department:**	
City Volunteer?	☐ Yes ☐ No	**If Yes, Department:**	

Name:	First	Middle	Last

Home Address:		**Day Phone**	
City, State, Zip		**Evening Phone:**	
		Cell Phone:	

Provide a detailed description of the incident and injury/illness (if occurred):

Witness Signature **Date**