CITY OF GRAND HAVEN
OCCUPATIONAL INJURY/ILLNESS REPORT

Employee Information

Name: ______________________________ Job Title: ______________________________

Department: ______________________________ Shift Start Time: ______________________

Incident Information

Date/Time of Incident: ____________________ Reported to: ___________________________

Date/Time Injury Reported: _______________________ On Employer Premises? ☐ Yes ☐ No

Address Where Injury Occurred: ____

Were proper work procedures being following? ☐ Yes ☐ No- Provide explanation on back of form

Description of Incident (If exposure, also include the Exposure Worksheet):

Body Part(s) Injured: ____

Treatment Information

Was the employee asked if they wanted to seek medical treatment? ☐ Yes ☐ No

Did the employee seek medical treatment? ☐ Yes ☐ No
If yes, was the employee treated: ☐ On-site ☐ Workplace Health ☐ NOCH ☐ Other: ________

Following treatment, the employee returned to work:
☐ Same Day ☐ Next Shift ☐ Other: ____

Preventable measures recommended addressing the underlying cause of accident:

By signing below, you attest to have completed this report thoroughly and accurately to the best of your knowledge.

Supervisor's Signature	Supervisor's Name (Print)	Date

Employee's Signature	Date