



City of Traverse City Injury Report

TO BE COMPLETED BY EMPLOYEE:

Please Print

1. Name _____ 2. Birthdate _____
(Last) (First) (Middle)

3. Home Address _____ 4. _____
(# and Street) (HOME phone #)

_____ 5. Marital Status: M____ S____
(City) (State) (Zip Code)

6. Job Classification _____ 7. Time Employee Begins Work _____

8. Date of Injury _____ 9. Time of Injury _____ 10. Witnessed By _____

11. What Kind of Injury? (Contusion, cut, fracture, sprain, strain, etc.) _____

12. Body Part Injured (left leg, right arm, back, etc.) _____

13. How Did Injury Occur? _____

14. Where Did The Injury Occur? (location) _____

15. Injury Reported To _____ 16. Time _____ 17. Date _____
(Supervisor)

18. Is This A Re-injury? _____ 19. Date of Original Injury? _____ 20. Reported to Employer? Yes ___ No ___

Other Employment: 21. Do You Have Any Other Jobs (or are you self-employed)? Yes ___ No ___

22. If Yes, Name of That Employer _____

23. Are you Losing Time From That Job? Yes ___ No ___

Employee Signature _____ Date _____



City of Traverse City Injury Report

TO BE COMPLETED BY SUPERVISOR:

Please Print

24. Injured Employee's Name _____
25. Is the Date, Time, and Location of the Injury Correct? Yes ____ No ____ (If No, please explain with accurate facts)

26. Was the Employee Sent for Medical Treatment? Yes ____ No ____
Where? _____ What Time? _____
27. Has the Employee Returned To Work? Yes ____ No ____ (If Yes, what date and time did the employee return?)

28. Why did this Injury Occur? _____

29. What Corrective Actions Have You Taken to Prevent Reoccurrence of this Type of Injury? _____

Other Employment or Outside Activities:

27. Does this Employee Have Another Job (or are they self-employed) Yes ____ No ____

If yes, with whom? _____

Supervisor Signature _____ Date _____

**City of Traverse City
Medical Authorization**

From: City of Traverse City
400 Boardman Avenue
Traverse City, MI 49684

Attn: J. Delaney
Human Resources Director
231.922.4481

1. Date _____
2. Employee's Name _____
3. Job Classification _____ 4. Date of Injury _____
5. Description of Injury or Problem _____
- _____

Signature of Person Authorizing Medical Treatment _____

The following Section is to Be Completed by the Physician

Doctor's Report: Please fill in the information below completely and have the employee return the completed form to his/her supervisor immediately following this treatment.

6. Diagnosis _____
7. Treatment Rendered _____
8. Is Further Treatment Necessary? Yes ____ No ____ If yes, what type? _____
- _____
9. Referred to Another Physician? Yes ____ No ____ Who? _____
10. Medication Prescribed? Yes ____ No ____ What and What Are the Restrictions Associated with the Medication(s)?
- _____
11. Employee May Return To Work as Follows: _____ Today, No Restrictions
_____ Today, With Restrictions as Indicated Below
_____ Tomorrow, No Restrictions
_____ Tomorrow, With Restrictions as Indicated Below
_____ Other, Please Specify _____

Restrictions _____

Date _____

Doctor Signature _____

Printed Name _____