

**MIAMI COUNTY  
PERSONNEL POLICY MANUAL**

**OCCUPATIONAL ILLNESS OR INJURY REPORT FORM**

**FORM 26  
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**To be completed immediately and given to supervisor**

Employee's Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Home Address: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Classification: \_\_\_\_\_

Department: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

Date Reported: \_\_\_\_\_ Time \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

To whom was injury reported? \_\_\_\_\_

Description of injury (be specific — name any objects or substances involved): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Part(s) of body injured: \_\_\_\_\_

\_\_\_\_\_

Name(s) of witness (es): \_\_\_\_\_

\_\_\_\_\_

Was any medical or emergency treatment necessary?      Yes      No

If so, state name of physician and/or hospital: \_\_\_\_\_

\_\_\_\_\_

Is this an aggravation of a previous injury?      Yes      No

Have you ever had a similar injury?      Yes      No

Lost time from work (estimated): \_\_\_\_\_ days \_\_\_\_\_ hours \_\_\_\_\_ none

By signing this form I expressly waive all provisions of law which forbid any person or persons who heretofore did or who hereafter may medically attend, treat or examine me or who may have information of any kind which may be used to render a decision in my claim for injury/disease of \_\_\_\_\_, 20\_\_\_\_ from disclosing such knowledge to my employer and/or any representative of employer. A copy of this form will serve same as the original.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

(Print Name) \_\_\_\_\_

**PART II. SUPERVISOR'S REPORT**

Exceptions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Supervisor's signature is verification that the validity and completeness of the above statement has been checked.

Date Completed: \_\_\_\_\_