

FORM 2.10 Notice of Work Injury

Name of injured person: _____

Date of injury: _____

Time the injury occurred: _____

Cause of injury:

What were you doing at the time of Injury?

What was injured? Please note left or right if applicable.

Did you report the accident immediately? _____ To whom? _____
If not, what was your reason?

Have you seen or do you plan to see a doctor? _____
(If you miss work due to an accident, you must see a doctor on the first day you miss work and provide medical updates until you return to work. You must provide a doctor's note upon returning to work stating limitations or return to full duties.)

Witness name: _____ **Phone #:** _____

Signature of Management: _____ **Date:** _____

Signature of injured worker: _____ **Date:** _____

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