

**Iredell County Employee
Injury/Illness Report Form**

Department _____

Address or Location Where Accident Occurred _____

Employee Full Name _____ Social Security # _____

Employee Address _____
Street City State Zip

DOB ___/___/___ Phone Number _____ Date of Hire ___/___/___ Male ___ Female ___

Wages per Hour _____ Number of Hours Worked Per Week _____ Full-time ___ Part-time _____

Job Title _____ Date of Incident ___/___/___ Time of Incident _____ am ___ pm ___

Time employee reported to work _____ am ___ pm ___ Date employer notified of incident ___/___/___

Specific Location of Incident (Ex: Stairs, ladder, auto, etc.) _____

Cause of Incident (describe in detail) _____

Type of injury received including body part (describe in detail) _____

Did you seek Medical attention? ___ Yes(attach MD statement) ___ No

Witnesses? If so, give name(s) _____

Employee Signature and Date _____ ___/___/___

Department Head Signature and Date _____ ___/___/___