MOVEMENT
ORTHOPEDICS

43475 Dalcoma Dr., Suite 250
Clinton Township, MI 48038
Phone: (586) 436-3785 | Fax: (833) 972-5451

Accident / Injury Report

Employee Information

Employee Name: _____ **DOB:** _____

Job Title: _____ **Department:** _____

Employer Information

Company Name: _____

Supervisor Name: _____ **Phone:** _____

Accident / Injury Details

Date of Injury: _____ **Time:** _____ ☐ AM ☐ PM

Location where injury occurred: _____

Was injury reported to employer? ☐ Yes ☐ No **Date reported:** _____

Describe in detail how the injury occurred:

Body part(s) injured (check all that apply):

☐ Head / Face	☐ Neck	☐ Shoulder ☐L ☐R	☐ Arm ☐L ☐R
☐ Elbow ☐L ☐R	☐ Wrist ☐L ☐R	☐ Hand / Fingers ☐L ☐R	☐ Upper Back
☐ Lower Back	☐ Hip ☐L ☐R	☐ Knee ☐L ☐R	☐ Leg ☐L ☐R
☐ Ankle ☐L ☐R	☐ Foot / Toes ☐L ☐R	☐ Chest / Ribs	☐ Other: _____

Type of injury: ☐ Fracture ☐ Sprain/Strain ☐ Laceration ☐ Contusion ☐ Dislocation ☐ Crush ☐ Other: _____

Were there witnesses? ☐ Yes ☐ No **Witness name(s):** _____

Was first aid provided? ☐ Yes ☐ No **By whom?** _____

Was employee sent to ER? ☐ Yes ☐ No **Hospital name:** _____

Current Status

Can employee return to work? ☐ Yes, full duty ☐ Yes, light/modified duty ☐ No, unable to work

Restrictions (if any): _____

Employee Signature / Date

Supervisor Signature / Date