Employee Report of Injury Form

Instructions: Employees shall use this form to report all work-related injuries or illnesses – no matter how minor. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by employees as soon as possible and given to a supervisor or Human Resources for further action.

Worker's Compensation Carrier Information

Hanover Policy #:	**WCZ J17556200**	Policy Term:	10/01/22-23
Hanover Phone:	800.628.0250	Email:	wcnewlosses@hanover.com

Injured Employee Information

Name		SSN:	
Street Address		Date of Birth:	
City, State Zip		Phone #:	
Job Title:		Hire Date:	
Supervisor:		Pay Rate:	
Work Address:		City, State, Zip	

Description of Injury

Date of Injury:		Time:	
Description of Injury (how, when, and where injury occurred):			
Body Part Affected (which side of body, if applicable)			
What could have been done to prevent this injury?			

Names of any/all Witnesses

Witness:	
Witness:	
Witness:	

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date