EMPLOYEE INJURY AND ILLNESS REPORT
ROMAN CATHOLIC DIOCESE OF ALBANY

SOCIAL SECURITY NUMBER	NAME (LAST) (FIRST) (M.I.)	SEX (M OR F)	MARITAL STATUS (M S D W

HOME ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

DATE OF BIRTH MO DA YR	AGE ( )	WORK STATUS PART OR FULL	YEARS WITH EMPLOYER	YEARS ON THE JOB	HRS/DAY	DAYS/WEE

OCCUPATION	IMMEDIATE SUPERVISOR	DEPARTMENT	AVERAGE EARNINGS PER WEE

EMPLOYEE'S STATEMENT (HOW AND WHY ACCIDENT OCCURRED)

WHERE DID INJURY OCCUR	EMPLOYEE'S SIGNATURE	DATE MO. DA. YR.

DATE OF INJURY OR ILLNESS MO. DA. YR.	HOUR OF DAY A.M. P.M.	DATE EMPLOYER ADVISED MO. DA. YR.

IS THIS A REOCCURRENCE OF A PREVIOUS INJURY OR ILLNESS	YES	NO	IF "YES" PLEASE GIVE DETAIL

INJURED BODY PARTS

SUPERVISOR'S STATEMENT (INCLUDE ACTION TAKEN TO PREVENT FUTURE OCCURRENCES)

NATURE OF ILLNESS OR INJURY

SUPERVISOR'S SIGNATURE	DATE MO. DA. YR.	

WITNESSES

NAME	ADDRESS
NAME	ADDRESS

EMPLOYEE SENT:	___HOME ___HOSPITAL	___ PHYSICIAN ___ NURSE'S OFFICE	NAME	ADDRESS

DATE OF FIRST FULL DAY OUT	ESTIMATED DATE OF RETURN TO REGULAR WORK	TO RESTRICTED WORK	AT LOWER WAGES YES	NO	DATE OF DEATH MO. DA. YR.

PREPARED BY (NAME) POSITION

(TO BE COMPLETED BY RISK MANAGEMENT OFFICE)

DATE REC'D MO DA YR	CASE REPORTABLE TO: W.C. MO DA YR	NOT REPORTABLE _____	CLASSIFICATION CODES TYPE	SOURCE	PART OF BODY	NATURE