CITY OF MADISON
FINANCE DEPARTMENT
Worker's Compensation
WC-1 (Rev 8/2018)

EMPLOYEE INJURY REPORT

OFFICE USE ONLY

Department/Division

INSTRUCTION: Employee to complete front part of form and submit to supervisor for completion.

PLEASE PRINT

Employee Name (Last, First, Middle)			Position	MUNIS Employee Number	
Employee Address			Home Telephone	MPD/MFD Report Number	
City	State	Zip Code	Work Telephone	Date of Birth	Date of Hire

What happened? Describe in detail.

When did you report the accident?	To whom was it reported?	How was it reported?
		☐ In Person ☐ Email ☐ Phone ☐ Text

WHERE & WHEN DID THE ACCIDENT HAPPEN? (Be Specific)

Location (Building name & room or street address)	Date	Time	Vehicle Number	Identification of Equipment Involved
		☐ AM ☐ PM		

Name(s) of other party(ies) involved, if a motor vehicle accident occurred

Name(s) of Witness(es)/Employee(s)

ACCIDENT TYPE (Check All That Apply)

- ☐ Struck Against or By
- ☐ Fall
- ☐ Caught In
- ☐ Punctured
- ☐ Lifting/Carrying
- ☐ Pulling/Pushing
- ☐ Throwing
- ☐ Struggle w/person
- ☐ Contact w/Electric Current
- ☐ Contact w/Temperature Extreme
- ☐ Inhalation of Substance
- ☐ Motor Vehicle Accident
- ☐ Other: (specify) _____
- ☐ Needlestick / Sharps contaminated? ☐ Y ☐ N
- ☐ Retractable / Self-Sheathing? ☐ Y ☐ N
  Type: _____

INJURY TYPE (Check All That Apply)

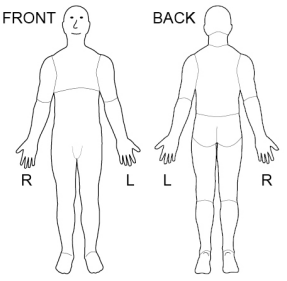
- ☐ Amputation
- ☐ Respiratory condition
- ☐ Burn or Scald
- ☐ Chemical Burn
- ☐ Concussion
- ☐ Contusion
- ☐ Laceration
- ☐ Skin condition/rash (also Poison Ivy)
- ☐ Dislocation
- ☐ Electric Shock
- ☐ Fracture
- ☐ Frostbite
- ☐ Hypothermia/Freezing
- ☐ Hearing Impairment
- ☐ Heat Exhaustion
- ☐ Hernia
- ☐ Irritation-Joints
- ☐ Poisoning-Systematic
- ☐ Foreign Body
- ☐ Sprains, Strains
- ☐ Multiple Injuries
- ☐ Other: (specify) _____

BODY PART (Check affected part[s])

Head
- ☐ Eye
- ☐ Ear
- ☐ Jaw
- ☐ Facial
- ☐ Nose
- ☐ Skull
- ☐ Multiple Body Parts

Trunk
- ☐ Neck/Upper Back
- ☐ Mid-Back
- ☐ Lower Back
- ☐ Chest
- ☐ Lungs
- ☐ Abdomen
- ☐ Hips
- ☐ Trunk, Multiple

Extremities (Indicate Left or Right)
- ☐ Finger
- ☐ Hand
- ☐ Wrist
- ☐ Forearm
- ☐ Elbow
- ☐ Upper Arm
- ☐ Shoulder
- ☐ Upper Extrem. Multiple
- ☐ Thigh
- ☐ Knee
- ☐ Calf
- ☐ Ankle
- ☐ Foot
- ☐ Toe
- ☐ Lower Extrem. Multiple



MEDICAL TREATMENT (Check Appropriate Item)

☐ Sought Medical Treatment Immediately
- Where? _____
- Healthcare Provider: _____
- Name/Contact: _____
- Date of Appointment: _____

☐ Scheduled Appt. w/Family Physician/Chiro.
- Where? _____
- Healthcare Provider: _____
- Name/Contact: _____
- Date of Appointment: _____

☐ Did Not Seek Medical Treatment

Additional comments regarding treatment:

Employee Signature	Date Signed