

VOLUNTEER FIREMAN INJURY AND ILLNESS REPORT

SOCIAL SECURITY NUMBER 	NAME (LAST) (FIRST) (M.I.)	SEX (M or F)	MARITAL STATUS (M. S. D. W. L.)
HOME ADDRESS	CITY	STATE	ZIP CODE
		DATE OF BIRTH	MO. DA. YR. / /
FIRE COMPANY NAME		ADDRESS	
FIRE DISTRICT	REGULAR EMPLOYER NAME	ADDRESS	
POLITICAL SUBDIVISION	IMMEDIATE SUPERVISOR		

VOLUNTEER FIREMAN'S STATEMENT (HOW AND WHY ACCIDENT OCCURRED?)

WHERE DID INJURY OCCUR?			
DATE OF INJURY OR ILLNESS MO. DA. YR. / /	HOUR OF DAY A.M. P.M.	DATE REGULAR EMPLOYER ADVISED MO. DA. YR. / /	DATE COUNTY ADVISED MO. DA. YR. / /
IS THIS A RE-OCCURRENCE OF A PREVIOUS INJURY OR ILLNESS?	YES	NO	IF "YES" PLEASE GIVE DETAILS

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

NATURE OF ILLNESS OR INJURY	
	INJURED PARTS

WITNESSES

NAME	ADDRESS		
NAME	ADDRESS		
EMPLOYEE SENT: <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL	<input type="checkbox"/> PHYSICIAN	NAME	ADDRESS
TREATED BY: NAME	ADDRESS	DATE MO. DA. YR. / /	
DATE OF FIRST FULL DATE OUT / /	ESTIMATE DATE OF RETURN TO REGULAR WORK TO RESTRICTED WORK / / / /	AT LOWER WAGES YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE OF DEATH MO. DA. YR. / /
PREPARED BY (NAME)	Is Fireman losing time from his Regular Employment? Yes <input type="checkbox"/> NO <input type="checkbox"/>		

COMMENTS

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