



7312 Parkway Drive
 Hanover, MD 21076
 800-336-7091 • 410-579-3970 FAX

EMPLOYEE INCIDENT REPORT

Each employee is required to complete this form after experiencing an unintentional work related injury. This form is used as official documentation that an on-the-job injury has occurred. Please be as specific as possible when completing this form. PLEASE PRINT CLEARLY.

Employee Information:

Employee Name	Complete Mailing Address (No P.O. Box)	Home Telephone Number	
Social Security Number	Job Title	Date of Birth	Marital Status
THE LAW PROVIDES FOR SEVERE PENALTIES IF YOU WITHHOLD A MATERIAL FACT OR MAKE A FALSE STATEMENT ON THIS OR ANY OTHER FORM TO OBTAIN WORKERS' COMPENSATION BENEFITS.			

Incident Information:

Date Injury Occurred	Time of Day Injury Occurred	Client Name
Address Where Injury Occurred	What was the Injury?	Date Returned To Work

Incident Occurrence:

How did the injury occur? *(Describe fully the events, which resulted in this injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors, which led or contributed to this claimed injury or disease.)*

Were any safeguards provided? Used? *If so, please explain:*

Did you report this incident to anyone at the Client? <i>If so, to whom and when did you report it?</i>	Did anyone witness this incident? <i>If so, please list names:</i>
Did you notify anyone at Allegis Group about this incident? <i>If so, to whom and when did you notify?</i>	

Medical Information:

Notification of Ability To Work:

Do/Did you require medical attention? <i>(Please explain. Name the doctor, clinic, address and phone number of facility you will see/were seen.)</i>	Did the Doctor report you could return to work? Y or N <i>If Yes, was it (circle one) FULL DUTIES or RESTRICTED DUTIES</i> If RESTRICTED, List your restrictions:
Was a Drug Screen performed? Y or N <i>If not, why?</i>	Have you returned to work? Y or N
Date and Time of Next Doctor's Appointment?	If No, please explain:
I hereby certify that the above statements are true to the best of my knowledge or belief. I am aware that the law provides for severe penalties if I knowingly and/or with fraudulent intent withhold a material fact or make a false statement on this or any other form in order to obtain workers' compensation benefits. Additionally, I understand that Allegis Group requests that I keep them apprised of my medical/work status at all times. I further understand that Allegis Group offers modified-duty assignments to employees based on prescribed medical limitations resulting from job related injuries. I agree to contact Allegis Group's Risk Management Department at 1-800-336-7091 to comply with this request.	
Employee Signature :	Date: