



EMPLOYEE INJURY REPORT
MURRAY CITY CORPORATION

Employee Information

Name Date of Birth Social Security #
Address City Zip Code
Home Phone Work Phone Cell
Gender: M F Date of Hire Number of Days Worked/Week
Department Job Title Supervisor
Wage Rate \$ Per: Hour Day Week Status: Full Time Part Time/Seasonal

Incident Information

Date of Injury Time of Injury am pm Date Employer Notified
Location of Incident (Facility, Address, etc.)
Did it Occur on Employer's Premises? Y N Did it Occur While Performing Regular Duties? Y N
Description of How Injury Occurred (Equipment used, Activity engaged in, etc.)
Were Safeguards or Safety Equipment Provided: Y N N/A Were They Used: Y N N/A
Witness Name (If applicable) Witness Phone Number

Injury Information

Type of Injury Part of Body Injured Left Right Bilateral
Description of Injury
Have You Injured This Part of Your Body Before? Yes No If Yes, Explain

Initial Treatment: No Medical Treatment First Aid Only Minor (WorkMed, InstaCare, etc.)
Emergency Room Hospitalized Referred to a Specialist

Hospital/Clinic Name Address

Release of Medical Information

I certify that the above information is true to the best of my knowledge. I authorize the release to Murray City and to Workers Compensation Fund, all records relevant to my disability and my claim for workers compensation benefits, including but not limited to medical diagnosis, prognosis, treatment, and periods of hospitalization. This authorization applies to physicians and other health care providers, hospitals and clinics, insurance companies and workers compensation carriers. This authorization will remain in effect throughout my claim for workers compensation benefits. A photo copy of this authorization will be as valid as the original.

Employee Signature Date