

**CITY OF HIALEAH**  
**EMPLOYEE INJURY REPORT**  
 (To be completed by Employee)

Employee's Name(first, middle, last): _____		
Social Security Number: _____	Date of Birth: _____	Sex: _____
Employee's Home Address: _____		
Employee's Home Telephone Number: _____		
Department: _____		
Supervisor's Name: _____	Telephone #: _____	
Occupation: _____	Employed since: _____	
Date of Accident: _____	Time of Accident: _____	
Place of Accident(Address): _____	Employer's Premises: Yes ___ No ___	
Has this accident happened to you before? Yes ___ No ___		
Has this accident happed to anyone else in your department? Yes ___ No ___		
Do you have a second job? Yes ___ No ___		
If yes, Employer's Name & Telephone #: _____		
<b>Describe the accident?</b> (State fully what you were doing at the time of the accident. State all factors contributing to the accident. If you need additional space for your statement please use separate paper.)		
_____		
_____		
_____		
Do you feel this accident was avoidable, and if so, how? _____		
_____		
Describe the part of the body that was injured: _____		
Witness Name: _____	Witness Telephone: _____	
Witness Name: _____	Witness Telephone: _____	
Do you wish to see a doctor? Yes ___ No ___		
If yes, contact the Risk Management Office at (305-883-8059) for the name of Doctor. If you have already seen a doctor, please provide name, address, and telephone number of Doctor.		
Name of Doctor: _____	Telephone #: _____	
Address: _____		
Do you require hospital treatment? Yes ___ No ___ Name of Hospital: _____		
Are you able to return to work? Yes ___ No ___		
<b>Note: If you received medical care, you will need to provide a DWC-25 or a doctor's note from the authorized workers' compensation physician or emergency room.</b>		
Are you requesting Workers' Compensation Benefits 70-66? Yes ___ No ___		
If yes, you must complete the Form 70-66 in Addendum #2.		
<b>I hereby certify that the above injury happened in the Scope of Work while employed by the City of Hialeah, and the report has been made to the best of my knowledge.</b>		

\_\_\_\_\_  
 Employee Signature

\_\_\_\_\_  
 Date File Reported