Lost-Time Injury Register

Register Information

Site/Location*: _____

Calendar Year*: _____

Prepared By*: _____

Contact Email: _____

Contact Phone: _____

Lost-Time Injury Recor

Injury Records:

Incident Date	Employee Name	Depa t	h Ti	re of	Body Part Affected	Days Lost	Return-to-Work Date	Medical Treatment	Workers Comp Claim	Supervisor Name	Date Reported

Options for 'Nature of Injury': Sprain/Strain, Fracture, Cut/Laceration, Burn, Contusion, Other
Options for 'Body Part Affected': Head, Neck, Shoulder, Arm, Hand, Torso, Back, Leg, Knee, Foot, Multiple, Other
Options for 'Medical Treatment': None, First Aid, Medical Treatment, Hospitalization
Options for 'Workers Comp Claim': Yes, No, Pending