

FOR OFFICIAL USE ONLY
Department of the Navy
Report of Traumatic Injury

For use by military personnel, non-appropriated fund civilian personnel and foreign nationals only.

Employee Data			
1. Name of employee (Last, First, Middle)			2. Social Security No.
3. Date of birth Mo. Day Yr.	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Home Telephone ()	6. Rank/Grade on date of injury:
7. Employee's home mailing address(include city, state, and zip code)			8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)			
10. Date of Injury Mo. Day Yr.	Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	10. Date of notice Mo. Day Yr.	12. Employee's Occupation
13. Cause of Injury (Describe what happened and why)			

14. Nature of Injury(identify both the injury and part of body, e.g., fracture of left leg)	a. Type code	b. Source code

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Employee Signature

15. I certify that the injury described above was sustained in performance of duty as an employee of the United States Navy and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication.

Signature of employee or person acting on his/her behalf

End of Employee Report

Witness

Note: Witness Statements, when available, should be attached to this report for use by the mishap investigator during the investigation of this injury.

16. Witnesses to the injury. (If additional witnesses are available who may provide more information, attach a separate sheet of paper with the below information)

Name of Witness	City	State	Zip Code	Daytime Telephone Number ()
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Name of Witness	City	State	Zip Code	Daytime Telephone Number ()
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Name of Witness	City	State	Zip Code	Daytime Telephone Number ()
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Supervisor's Report

17. UIC of activity reporting mishap:

18. UIC of activity where mishap occurred:

19. Employee's duty station (Street address and zip code)

20. Date of Injury Mo. Day Yr.	21. Days of Restricted Work beyond date of injury.	22. Number of lost work days.
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23. Was the employee injured in performance of duty? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain)	24. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No
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25. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? Yes No (If no, explain)

Signature of Supervisor and Filing Instructions.

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26. I certify that the information given above and that furnished by the employee is true to the best of my knowledge with the following exception:

Name of Supervisor (Type or print)

Signature of Supervisor

Date

Supervisor's Title

Office Phone

27. Filing instructions:
- No lost time and no medical expenses incurred. Provide to activity Safety Office for recordkeeping.
 - No lost time, medical expense incurred or expected. Provide to activity Safety Office for recordkeeping
 - Lost Time. Provide to activity Safety Office for recordkeeping
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