



## AWEP Participant Injury Report

Email Report  
 Attention: Arlalia Oldham-Wesley  
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<b>PARTICIPANT</b>	<b>Worksite ID#: AWEP PY18-19 _____ (Name of Worksite)</b>					
	Name (Last, First, Middle)		Date of Birth	SS# (Last 4)	Program Start Date	Program End Date
	Address		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		Occupation Job Title
	Phone		# Dependents			
<b>OCCURRENCE</b>	Time work began _____ am _____ pm		Date of Injury/illness	Time of Injury: _____ am _____ pm	First Date of Disability	
	Type of Injury (contusion, fracture, etc.)			Body part affected (included left, right, front or back)		
	How injury occurred? Describe the sequence of events. Include any objects or substances that directly injured the employee, specific activity employee was engaged in when accident or illness occurred. Use reverse, if necessary.					
	Was supervisor notified initially? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, who?			Date notified:		
	Witness (name & phone#)			Supervisor (name & phone#)		
	Date prepared:		Preparer's name:		Phone#:	
	Date return to internship:		If fatal, date of death:		Were safeguards provided? <input type="checkbox"/> Yes <input type="checkbox"/> No Were safeguards used? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>MEDICAL</b>	Health Care Provider (name & address)		Hospital (name & address)		Initial treatment: <input type="checkbox"/> No medical treatment <input type="checkbox"/> Minor by employer (First Aid) <input type="checkbox"/> Minor Clinic Hospital Emergency Case: <input type="checkbox"/> Hospitalized > 24 hrs.	
	Work Week: _____ Hours _____ Days					
<b>OTHER</b>	<b>OFFICIAL USE ONLY</b>					
	CareerSource Polk Project Manager			Date Received:		
	Copy of Report Provided to: _____			Date Provided:		