



OCCUPATIONAL INJURY OR ILLNESS REPORT

Please return to: KRISTI CELMER at TOBA.
email: kcelmer@tobafoods.com OR mail: 2621 W Hwy 30, Grand Island NE 68803

Date: _____

Name: _____
First Middle Last

Social Security Number: _____

Home Address: _____
Street

_____ *City State Zip*

Phone Number: _____

Date of Birth: _____ Age: _____

_____ Male _____ Female / _____ Single _____ Married

Number of children under 18 or incapacitated regardless of age: _____

Injured employee's scheduled work week at time of injury:

_____ Hours per day _____ Hours per week _____ Days per week

Place of accident or exposure to occupational illness (street address, city, county, state):

Was place of accident or exposure on company premises: __Yes _____ No

What were you actually doing when injured: _____



How did the accident occur?

When did you notify a representative of the company about the illness or injury?

Date of injury or diagnosis of illness: _____

Time your work day or shift began: _____

Time of injury or diagnosis of illness: _____

Were you working overtime? Yes No

Describe the injury or illness in detail and indicate the part of the body affected (be specific):

Name the object or substance which directly injured you: _____

Did your injury cause you to miss work? _____

Date disability began: _____

Probable length of total disability: _____

Is any permanent disability anticipated? Yes No

Date you returned to work: _____

Name and address of physician: _____

Name and address of clinic/hospital: _____

Name and address of witnesses: _____
