TOBA INC.

(308) 382-TOBA (8622) – info@tobafoods.com

Form: Occupational Injury or Illness Report

Please return to: PATRICK HOINS at TOBA.
email: phoins@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: _____
_____
_____

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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: _____

_____