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Form: Occupational Injury or Illness Report

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: _____
