FORM STD-28

Employee's Reporting Notification of Injury

Instructions: It is mandated for an employee to notify the employer within 30-days whenever an injury or death occurs at work. To report an injury, the employee must complete this form and submit to the employer within 30-days from the date of injury. A copy must also be provided to the Commission and the employer's insurance carrier. *** This form is not used for filing a claim ***

1. Date of Injury:	2. Time of Injury:	☐ AM ☐ PM	3. Type of Event: ☐ Injury | ☐ Fatality / Death

4. Name of Employee (First, Middle, Last):	5. Social Security No.:	6. Sex: ☐ Male | ☐ Female	7. Date of Birth:

8. Occupation:	9. Nationality:	10. Married: ☐ Yes | ☐ No	11. Number of Children under 18yrs. Old:

12. Place or Location of Where Injury or Death Occurred: ☐ Employer's Premises / Place of Business | ☐ Other (specify):	

13. Date First Visit the Hospital:	14. Name of Treating Physician or Doctor:	15. Have all Medical Treatments Completed? ☐ Yes | ☐ On-Going

16. Employment Status:	17. Employee's Mailing Address	18. Employee's Contact Information
☐ Career Service ☐ Contract ☐ Temporary Hire ☐ Casual Worker ☐ Minor, Apprentice, or Trainee ☐ Part-time ☐ Volunteer	_____ (Street, Apt. #, P.O. Box) _____ _____ (City, State, & Zip Code)	Tel: _____ Cell: _____ Email: _____

19. Is the injury or death caused by another person? ☐ No | ☐ Yes	20. Specify in detail the actual part of the body or area being injured:

21. Describe how the injury occurred and what caused such injury:

22. Name of Employer:	23. Name of Supervisor at time of injury:

X _____.
AUTHORIZED SIGNATURE OF EMPLOYEE

_____
DATE OF THIS REPORT

FORM DISTRIBUTION: Original – Employer | Copy – Carrier | Copy – Commission | Copy – Employee