VOLUNTEER FIREMAN INJURY AND ILLNESS REPORT

SOCIAL SECURITY NUMBER	NAME (LAST) (FIRST) (M.I.)			SEX (M or F)	MARITAL STATUS (M. S. D. W. L.)	
HOME ADDRESS	CITY	STATE	ZIP CODE	DATE OF BIRTH MO.DA.YR. / /		AGE

FIRE COMPANY NAME	ADDRESS

FIRE DISTRICT	REGULAR EMPLOYER NAME	ADDRESS
POLITICAL SUBDIVISION	IMMEDIATE SUPERVISOR	

VOLUNTEER FIREMAN'S STATEMENT (HOW AND WHY ACCIDENT OCCURRED?)

WHERE DID INJURY OCCUR?			
DATE OF INJURY OR ILLNESS MO. DA. YR. / /	HOUR OF DAY A.M. P.M.	DATE REGULAR EMPLOYER ADVISED MO. DA. YR. / /	DATE COUNTY ADVISED MO. DA. YR. / /

IS THIS A RE-OCCURRENCE OF A PREVIOUS INJURY OR ILLNESS?	YES	NO	IF "YES"PLEASE GIVE DETAILS

FIRE CHIEF'S STATEMENT (INCLUDE ACTION TAKEN TO PREVENT FUTURE OCCURRENCES)

NATURE OF ILLNESS OR INJURY	
	INJURED PARTS

WITNESSES

NAME	ADDRESS
NAME	ADDRESS
EMPLOYEE SENT: ☐ HOME ☐ HOSPITAL ☐ PHYSICIAN	NAME ADDRESS

TREATED BY: NAME	ADDRESS	DATE MO. DA. YR. / /

DATE OF FIRST FULL DATE OUT / /	ESTIMATE DATE OF RETURN TO REGULAR WORK / / TO RESTRICTED WORK / /	AT LOWER WAGES YES ☐ NO ☐	DATE OF DEATH MO. DA. YR. / /
PREPARED BY (NAME)	Is Fireman losing time from his Regular Employment? Yes ☐ NO ☐		

COMMENTS