When injured on the job contact Human Resources (HR) Immediately at 419-422-5742; and complete this form and the First Report of Injury, Occupational Disease or Death Form and submit to HR by scanning to garner@garnertrucking.com. Revised April 2019

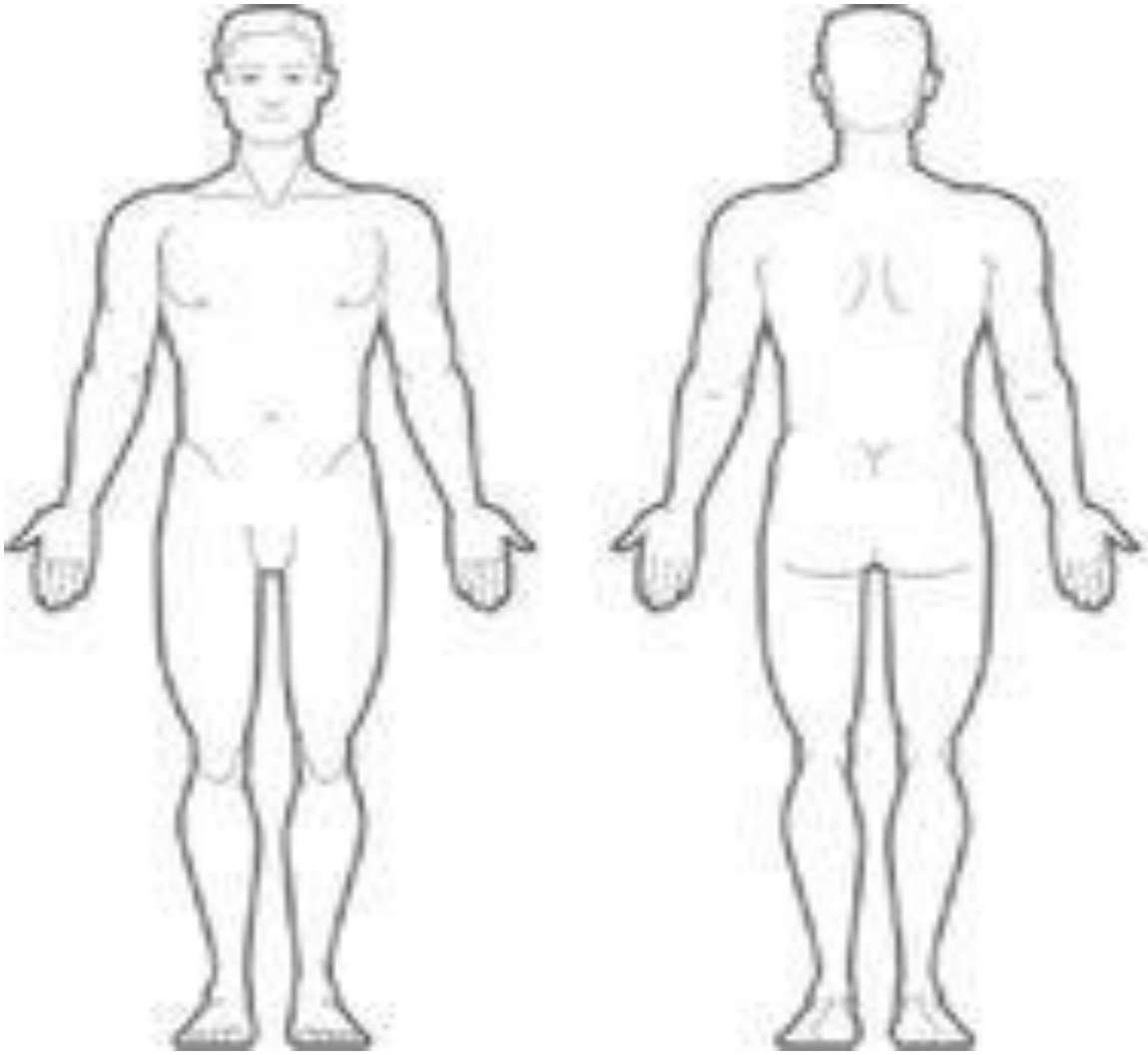
Injury Identification Log

Employee/Injured Name (Printed)_____

Date of Injury_____ Time of Injury_____ Time Began Work_____
(dd/mm/yyyy) (a.m. or p.m.) (a.m. or p.m.)

Location of Injury_____
(Facility Name) (City) (State)

1. Please circle all areas on your body that are/were injured/hurt on the date of injury noted above:



Front Back

2. Please list all areas of your body that sustained injury on the date of injury noted above; and please describe the injury.

_____

_____

_____

_____
_____
_____
_____

Circle One

3. Were there any witnesses to this incident? Yes No

    a. If you answered yes to question 4, please provide names, telephone numbers, addresses, etc. of all witnesses.

_____
_____
_____
_____

4. Have you ever sustained any injuries to the body part(s) you are claiming now? Yes No

    a. If you answered yes to question 4, please list the body part that was injured previously, the nature of that injury, date of previous injury and the name of doctor or health care provider who treated you for this injury.

_____
_____
_____
_____

5. Have you sought medical treatment for your current injury? Yes No

    a. If you answered yes to question 5, please provide the name of the doctor who treated you, name of facility where you sought medical treatment, and the date of treatment.

_____
_____
_____
_____

I affirm that the information I have provide is true and accurate. I also affirm that I sustained no other injuries than those noted above.

_____ _____
Printed Name of Injured Party Printed Name Company Representative

_____ _____
Signature of Injured Party Signature of Company Representative

_____
Date