# PERSONNEL INJURY REPORT

**(This form must be filled out before close of Supervisor's/Manager's shift)**

**FEGS-600**
Revision : 0
Date : 12-15-17

## F&E Ground Services LLC

Date Form Initiated: _____

| PERSONAL DATA | | | |
|---|---|---|---|
| Employee Name: | | | Employee #: |
| Home Phone #: | | Cell Phone #: | |
| Address: | | | |
| City: | State: | | Zip Code: |
| Schedule: | | Time Shift Started (local): | |

| INJURY DATA | | | |
|---|---|---|---|
| Station: | City: | Date: | Time (local): |
| Where did the injury occur? (Check the appropriate location) ☐ Ramp ☐ Hangar ☐ Office ☐ Aircraft | | | |
| Other (explain): | | | |
| Weather/Ramp Conditions: | | | |
| Part(s) of Body Injured: | | | |
| Was any Personal Protective Equipment (PPE) worn at the time of the injury? (eg. bump caps, fall restraint devices, etc.) ☐ Yes ☐ No ☐ N/A PPE worn at time of injury: | | | |
| Description of Injury: (Use a separate sheet of paper to provide additional information, if necessary) | | | |

| WITNESSES (All witnesses are required to document their statement on attached form FEGS-603. Use one form per witness) | | |
|---|---|---|
| 1. Name: | Home Phone #: | Cell Phone #: |
| 2. Name: | Home Phone #: | Cell Phone #: |
| Other Witnesses: | | |

| MEDICAL TREATMENT | |
|---|---|
| Was the AIG Nurse Triage line (855-365-7279) called to report injury? ☐ Yes ☐ No<br>If 'No', provide reason: | |
| Did employee receive medical treatment? ☐ Yes ☐ No | Date of Treatment: |
| Was employee taken by emergency transportation? ☐ Yes ☐ No | |
| Name of Treatment Facility: | |
| Did employee return to work the same day? ☐ Yes ☐ No | Lost Time (in days): |

Report Completed By (Supervisor's/Manager's Name):