GREYSTOKE HOME HEALTH

Staff Injury Report Form

CBI HEALTH GROUP

Date of injury or illness: _____ Time: _____ ☐am ☐pm
Day Month Year

Date injury or illness reported: _____ Time: _____ ☐am ☐pm
Day Month Year

Full name of injured or ill worker: _____

What part of your body was injured? _____ ☐ Left Side ☐ Right Side

Description of the injury or illness: _____

_____

_____

_____

Did the injury take place at work? ☐ Yes ☐ No

Description of where the injury or illness occurred/began: _____

_____

_____

_____

Cause of the injury or illness: _____

_____

_____

Treatment Provided: ☐ Physician ☐ Chiropractic ☐ Physiotherapy ☐ Other

Explain and provide name of Clinic and Professional providing treatment:

_____

_____

_____

Is this a WCB claim? ☐ Yes ☐ No

Date WCB contacted _____ Contacted by _____

This form gives the appropriate representative of CBI Greystoke Home Health permission to contact the Professional(s) providing treatment should it become necessary.

Staff Signature _____ Date _____

Supervisor Signature _____ Date _____