



**Heart and Lung Act Policy**  
**REPORT OF INJURY**

Employee Name:

Date of Injury/Date of Onset:

Explanation of how injury/disability occurred:

*Attach additional pages if necessary.*

Witnesses to injury/event resulting in disability:

Employee certifies that the information provided in this leave request is true and correct, and that providing false information on this Report of Injury is grounds for discipline, up to and including, termination.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_