VIRGINIA DEPARTMENT OF EMERGENCY MANAGEMENT
EMPLOYEE INCIDENT REPORT (EIR)

Please complete this form for any work-related injury and forward to your supervisor. (This form must be attached to the Employer's Accident Report)

Employee's Name: _____

Job Title: _____

Department: _____

Describe in detail how and where the injury occurred, noting any witnesses. Also describe the nature of the injury or illness, including parts of the body that are affected, i.e. (left leg, right ankle)

Date of Injury: _____ Time of Injury: _____

Witnesses: _____

City or County where accident occurred: _____

Detailed Description: _____

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Employees Signature Date

01/01