





***Town of Harrisburg  
Accident / Injury / Illness / Exposure  
Report and Investigation***

**MEDICAL TREATMENT/FOLLOW UP REPORT**

Name of Employee: \_\_\_\_\_

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

Did you seek medical treatment?    Yes \_\_\_\_\_    No \_\_\_\_\_    *(If No, explain why?)*

Where did you get medical treatment? \_\_\_\_\_

Who provided medical treatment? (Doctor's name) \_\_\_\_\_

What were you treated for? \_\_\_\_\_

What medical procedures were done? \_\_\_\_\_

Any type follow-up required?    Yes \_\_\_\_\_    No \_\_\_\_\_    *(If yes, please list dates below)*

_____ (Date)	Were you released for duty?	Yes _____	No _____
_____ (Date)	Were you released for duty?	Yes _____	No _____
_____ (Date)	Were you released for duty?	Yes _____	No _____
_____ (Date)	Were you released for duty?	Yes _____	No _____

Any restricted duties?    Yes \_\_\_\_\_    No \_\_\_\_\_    *If yes, How Long?* \_\_\_\_\_

Did you receive a prescription?    Yes \_\_\_\_\_    No \_\_\_\_\_

Did you receive a note from the doctor for light duty or released for work? \_\_\_\_\_

On what day were you released from light or restricted duty? \_\_\_\_\_

Employee's Signature: *(required)* \_\_\_\_\_

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

**Note: This form must be completed before employee returns to work. All paperwork received from the doctor should be attached to this form.**

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**Safety Committee comments:**

**Date Reviewed:**


**Safety Committee Chairman Signature:** \_\_\_\_\_