C.H.T.Services,Inc.

2901 Campus Road, Brooklyn, NY 11210
Phone: (718)874-6226 Ext. 101. **Fax:** (718)874-0041
www: chtservices.com

Record of Injury

Injury Date: _____ **Time:** _____ **AM / PM**

Injured Person Name: _____ **ID#** (if applicable) _____

Age of Injured Person: _____ **Sex: M F**

Name of the person completed the report:_____

Location of Injury: _____

Description of How the Injury Occurred:

_____
_____
_____

Incident's witness (Name, Address & Phone number):

_____
_____
_____

Body Part(s) involved:

_____
_____
_____

Actions taken on behalf of the injured child/adult:

_____
_____
_____

Recommendations of preventive strategies to avoid further occurrences of this type of injury:

_____
_____
_____

Therapist (Employee) signature: _____

Therapist (Employee) name& title: _____