ACCIDENT REPORT

PLEASE PRINT CLEARLY. COMPLETE WITHIN 24 HOURS.

1. GENERAL INFORMATION

Employee Name _____ Employee Address _____

( ) _____ _____

Employee Telephone Number Job Title

Employer _____ Exact Location of Accident _____

Date/Time of Accident _____ Date/Time of Injury Report and To Whom _____

2. DESCRIPTION OF INJURY/ILLNESS (Be as specific as possible.)

- Type of Accident (fall, etc.): _____
- Type of Injury (sprain, etc.): _____
- Body Part(s) Affected: _____

Was first aid administered on job site? Yes No If yes, by whom? _____

Were employee's injuries treated by a medical provider? (If yes, fill in provider information below.):

- Hospital: _____ Telephone Number: _____
- Clinic: _____ Telephone Number: _____
- Doctor: _____ Telephone Number: _____

Loss of time? Yes No First day of lost time: _____

Has employee returned to work? Yes No Date: _____

3. DESCRIPTION OF INCIDENT (To be completed by SUPERVISOR AND EMPLOYEE)

What happened? How did it happen? Was the injury caused by equipment malfunction? Specify what job was being performed: _____

_____

_____

Name(s) of Witnesses (Use reverse side for statements.): _____

_____

4. ANALYSIS

What was the cause of the incident? _____

_____

Contributing factors (physical surroundings, etc.): _____

_____

Did employee violate safety regulations or instructions? _____

_____

What actions will be taken to prevent a recurrence? _____

_____

What other concerns do you have about this injury, if any? _____

_____

Does the employee have other employment? Yes No If yes, where? _____

Contact Person at Other Employer: _____ Telephone Number: _____

Hours/Week: _____ Hourly Wage: _____

Supervisor's Signature: _____ Date: _____

Employee's Signature: _____ Date: _____