EMPLOYEE ACCIDENT REPORT

All questions must be answered completely:

Name _____

Address _____

Street City State Zip Code

Home Telephone (____) _____ Work Telephone (____) _____

Date of birth ____/____/____ Age _____ Social Security # _____ - _____ - _____

Date of Accident ____/____/____ Time Of accident _____ a.m./p.m.

Working shift from _____ a.m./p.m. to _____ a.m./p.m.

Days off (circle) M T W TH F S S

Location of accident (by area) _____

_____

Name of Supervisor _____

Witness(es) 1)_____ 2)_____

3)_____ 4)_____

Describe accident in detail (*How did the accident occur? Be specific)*:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Please use the back of this form in you need additional room to describe the accident.)

Nature of injury and parts of the body injured: _____

_____

_____

_____ _____

Employee signature Date

Original: Work Comp file
cc: Supervisor
Work Comp provider
Safety Office