# Howard Memorial Hospital
## Employee Accident & Injury Report

Name:________________________________ Emp. #_______________Department:________________

Title:_________________________________DOB:_________________DOH:______________________

Address:_________________________________________City:_______________________State:_____

Phone: (Home)________________________Cell:________________________Message______________

Date of Incident:______________________Time:_______________Day of Week:___________________

Reported to:_____________________________________________Date____________Time__________

Place of incident:__________________MEDCOR called:______Date:_______________ Time:_________

Incident Description:____________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Nature of injury/illness: (describe the part of body)___________________________________________

________________________________________________________________________________________

Action: W/C Doctor visit:_____Dr. Name:_______________________ date and time_________________

ER:____Dr. Name_________________Procedures:____________________________________________

Witnessed______Name_________________________________________________Title_____________

Witness statement:______________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________Signature of Witness________________________________

What defective or otherwise unsafe condition of tools, equipment, machinery, structures, or work area contributed directly to the incident. If there was no unsafe condition, so state.______________________

________________________________________________________________________________________

Employee Signature________________________________________Date/Time_____________________
Supervisor______________________________________________Date/Time_____________________

Employee Health Nurse:_________________________________Date/Time______________________
Followup:________________________________________________________________________________

________________________________________________________________________________________

HR:_______________________________________Date/Time___________________________________
W/Comp (LR)__________________________________________________Date/Time______________

Original to W/C Coordinator | Copy to Employee Health Nurse | Copy to Director/Supervisor