Sample Employee Accident Report

This form is to be completed by the employee and their supervisor at the time of the employee accident/illness and returned to the Workers Compensation Department. Attach any physician's statements, reports, or bills if available.

EMPLOYEE INFORMATION

Name:_______________________________SSN:____________________Birth Date:____________

Address:____________________________ City:________________ State:_______ Zip:_________

Home Phone:_______________________ Company Location:_____________________________

JOB INFORMATION

Position:____________________HireDate:____________________Full/Part Time/Other:___________

Shift Hours:_______________ Hours worked per day:_____________ Hours worked per week:_____________

Supervisor Name: ____________________________________ Supervisor Phone:______________________

INJURY/ILLNESS INFORMATION

Date of Injury or onset of Illness: _______________Time of Accident:_________ During Regular Duties?_____

Date Injury/Illness Reported: ____________________ To whom: ___________________________________

Location of accident if other than company location:____

Describe events that caused the Injury or Illness:____

____

How could the injury have been prevented? ____

Describe Injuries/Illness. Note specific parts of body that are directly affected: ____________________________

Have you ever had this type of injury before? ☐ No ☐ Yes If yes list date of prior injury.__________________

Have you engaged in any activity outside of work which may have contributed to your injury? ☐ No ☐ Yes

If yes, describe: ____

Provide name and work number of any person who witnessed the accident:

Name: ______________________________ Phone Number: _________________________________

Was medical attention offered? ☐ No ☐ Yes

Did employee require medical attention? ☐ No ☐ Yes If "yes", name and phone number of treating doctor/clinic:

____

Additional Comments:____

____

I represent that the statements and answers given are true and complete to the best of my knowledge and belief.
I understand that falsification of information could result in disciplinary action up to and including termination.

_________________________________ _________________________________

Employee Signature **Date** **Supervisor Signature** **Date**