Employee Accident Report Form

Date of Report:Click here to enter text. Date of lnjury: Click here to enter a date.

Injured Employee:Click here to enter text. S.S. #: Click here to enter text.

Home Address:Click here to enter text. Telephone #: Click here to enter text.

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Work Assignment: Building: Click here to enter text.

Birthdate: Click here to enter text. Sex: F [ ]  M[ ]

Time injury occurred: Click here to enter text. a.m. [ ] p.m.[ ]

Was place of accident or exposure on employer's premises? Yes[ ]  No[ ]

Nature of injury (i.e. burn, sprain, cut, etc.): Click here to enter text.

Part of body (i.e. right arm, left hand, head, etc.): Click here to enter text.

Describe the events that caused the injury: Click here to enter text.

Does employee wish to be seen at employers clinic? Yes [ ]  No[ ]

If no, reason for declining to go: Click here to enter text.

Was employee transported from the building? Yes[ ] No[ ]

If yes, please explain: Click here to enter text.

Was first aid administered? Yes[ ] No[ ]

If yes, please describe what first aid and by whom it was administered: Click here to enter text.

Signature of employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of person completing report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 6/20/2017 sm