WORK-RELATED ACCIDENT / INJURY REPORT FORM

INSTRUCTIONS

This form shall be completed as soon as possible following an employee-related accident or injury. If the employee is unable, the supervisor shall complete this form, and then submit it to the Human Resources office.

CLAIM NO.

PERSONAL INFORMATION

EMPLOYEE NAME	SOCIAL SECURITY NO.	EMPLOYEE ID	TODAYS DATE

JOB TITLE	DATE OF HIRE	RATE OF PAY

HOME ADDRESS	HOME PHONE	WORK PHONE

SUPERVISOR NAME	SUPERVISOR EMAIL	PHONE

EMPLOYEE STATUS				HOURS PER DAY	DAYS PER WEEK
	FULL-TIME		PART-TIME		

INJURY / ACCIDENT INFORMATION

LOCATION OF INJURY	DATE OF INJURY	TIME OF INJURY

DID THE INJURY CAUSE LOSS OF TIME FROM WORK? Provide dates, amount of time	HAS THE EMPLOYEE RETURNED TO WORK?

WITNESSES Provide names of any witnesses to the accident / injury

INJURY DESCRIPTION What parts of the body were affected? What type of injury?

INCIDENT DESCRIPTION What was the employee doing at the time of the incident? How did the injury occur?

INJURY / ACCIDENT TREATMENT

FIRST AID Describe any First Aid given at the scene of the injury / accident.

WAS INJURED PARTY TREATED IN AN EMERGENCY ROOM?				WAS INJURED PARTY TAKEN BY AMBULANCE?			
	YES		NO		YES		NO

NAME OF TREATING DOCTOR	NAME MEDICAL PROVIDER(S)

ADDRESS	PHONE

TREATMENT RECEIVED

SIGNATURE

	NAME	SIGNATURE	DATE
EMPLOYEE			
- OR - SUPERVISOR			

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