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# ACCIDENT REPORT

**PLEASE PRINT CLEARLY. COMPLETE WITHIN 24 HOURS.**

## 1. GENERAL INFORMATION

Employee Name _____ Employee Address _____

( ) _____ Job Title _____

Employee Telephone Number

Employer _____ Exact Location of Accident _____

Date/Time of Accident _____ Date/Time of Injury Report and To Whom _____

## 2. DESCRIPTION OF INJURY/ILLNESS (Be as specific as possible.)

- Type of Accident (fall, etc.): _____
- Type of Injury (sprain, etc.): _____
- Body Part(s ) Affected: _____

Was first aid administered on job site? Yes ☐ No ☐ If yes, by whom? _____

Were employee's injuries treated by a medical provider? (If yes, fill in provider information below.):

- Hospital: _____ Telephone Number: _____
- Clinic: _____ Telephone Number: _____
- Doctor: _____ Telephone Number: _____

Loss of time? Yes ☐ No ☐ First day of lost time: _____

Has employee returned to work? Yes ☐ No ☐ Date: _____

## 3. DESCRIPTION OF INCIDENT (To be completed by SUPERVISOR AND EMPLOYEE)

What happened? How did it happen? Was the injury caused by equipment malfunction? Specify what job was being performed: _____

Name(s) of Witnesses (Use reverse side for statements.): _____

## 4. ANALYSIS

What was the cause of the incident? _____

Contributing factors (physical surroundings, etc.): _____

Did employee violate safety regulations or instructions? _____

What actions will be taken to prevent a recurrence? _____

What other concerns do you have about this injury, if any? _____

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Does the employee have other employment? Yes ☐ No ☐ If yes, where? _____

Contact Person at Other Employer: _____ Telephone Number: _____

Hours/Week: _____ Hourly Wage: _____

Supervisor's Signature: _____ Date: _____

Employee's Signature: _____ Date: _____