EMPLOYEE ACCIDENT/INCIDENT FORM

EMPLOYEE INFORMATION

☐ MALE

☐ FEMALE

NAME ________ HOME PHONE # ________ CELL PHONE # ________

HOME ADDRESS ________ CITY ________ ST ________ ZIP ________ DEPARTMENT ________

DOB ________ AGE ________ DOH ________ WEEKLY HOURS ________ JOB TITLE ________

ACCIDENT INFORMATION

NAME OF PERSON COMPLETING REPORT: ____

DATE OF ACCIDENT:________________ TIME OF ACCIDENT:________________ ☐ AM ☐ PM TIME SHIFT BEGAN:_________ ☐ AM ☐ PM

WHEN WAS THE ACCIDENT REPORTED: ________________ ☐ AM ☐ PM WHO REPORTED THE ACCIDENT: ________________________

LOCATION OF ACCIDENT (SPECIFIC)

DESCRIPTION OF ACCIDENT – PLEASE INCLUDE ALL DETAILS

WHAT BODY PART(S) WERE AFFECTED/INJURED: ________________________________ WHAT OBJECT(S) SPECIFICALLY HARMED

EMPLOYEE DURING ACCIDENT (SAW, BLADE, CONCRETE, ETC): ____

DID EMPLOYEE SEEK MEDICAL TREATMENT: ☐ YES ☐ NO NAME OF TREATING FACILITY/PHYSICIAN:________________________

DID EMPLOYEE LEAVE WORK? ☐ YES ☐ NO DATE EMPLOYEE RETURNED TO WORK: _____________ NUMBER OF DAYS LOST:________

DID EMPLOYEE REFUSE MEDICAL TREATMENT: ☐ YES ☐ NO IF YES, EMPLOYEE MUST SIGN HERE:________________________

WAS THIS A NORMAL PART OF EMPLOYEE'S JOB DUTIES: ☐ YES ☐ NO WERE SAFETY MEASURES AVAILABLE: ☐ YES ☐ NO

IF SAFETY MEASURES WERE AVAILABLE, WERE THEY IN USE AT THE TIME OF ACCIDENT: ☐ YES ☐ NO IF NO, WHY NOT: _____________

WERE WITNESSES PRESENT: ☐ YES ☐ NO NAMES/PHONES: ____

EMPLOYEE SIGNATURE: ____ DATE:__________________

I understand that I have 2 years from the date of this report to file a worker's compensation claim.

SUPERVISOR REPORT

NAME:____ PHONE: ________________________ TITLE:__________________________

____ Improper maintenance ____ Poor housekeeping ____ Failure to secure ____ Improper protective equipment

____ Poor ventilation ____ Horseplay ____ Inoperative safety device ____ Unsafe arrangement or process ____ Improper dress

____ Lack of training or skill ____ Unsafe equipment ____ Operating without authority ____ Unsafe position

____ Improper instruction ____ Physical or mental impairment ____ Other ____________________

Supervisor's corrective action to ensure this type of accident does not recur: ____

Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures? ☐ YES ☐ NO

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? ☐ YES ☐ NO

Did employee promptly report the injury/illness? ☐ YES ☐ NO Is there modified duty available? ☐ YES ☐ NO

SUPERVISOR SIGNATURE: ______________________________ DATE: ______________