



Employee's Report of Accident

EMPLOYEE INFORMATION

Employee: Age: Sex:
Job Position/Title: SSN:
Supervisor's Name: Shift Hours: Days Off:

ACCIDENT INFORMATION

Date/Time of Accident: Location of Accident:

Date/Time of Accident Reported: To Whom:

Task being performed when accident occurred:

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Name of Witness(es):

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Describe how the accident occurred:

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What part of your body was injured:

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Describe the injuries in detail:

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Date/time you first sought medical attention:

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Name of doctor and/or hospital:

Signature of Employee: Date:

Supervisor Comments:
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Signature of Supervisor: Date:
Received in office by: Date: