ACCIDENT REPORT

EMPLOYEE SECTION

EMPLOYEE NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

SEX: ☐ MALE ☐ FEMALE PHONE NUMBER: _____

OCCUPATION: _____ DEPARTMENT: _____

HIRE DATE: _____

DATE OF ALLEGED ACCIDENT: _____ DATE REPORTED: _____

TIME OF ALLEGED ACCIDENT: _____ A.M./P.M. TIME REPORTED: _____ A.M./P.M.

EMPLOYEE'S DESCRIPTION OF ALLEGED ACCIDENT:

_____

_____

_____

_____

PLEASE NOTE: The employee must initial the description of the alleged accident. *Employee's Initials*: _____

BODY PART INJURED (Be specific): _____

HAVE YOU EVER INJURED THIS BODY PART BEFORE? ☐ YES ☐ NO

If yes, give the date: _____

Explain in detail:

_____

_____

_____

WITNESS NAME: _____

DID EMPLOYEE SEEK MEDICAL TREATMENT? ☐ YES ☐ NO

NAME/ADDRESS OF HOSPITAL: _____

NAME/ADDRESS OF ATTENDING PHYSICIAN: _____

Was Claimant Disabled From Work? ☐ Yes ☐ No Last Day Worked _____ Return to Work Date _____

I, the injured employee as stated herein, certify that the above information is true and correct.

_____ _____

Signature of Employee Date Signature of Supervisor Date

EMPLOYER SECTION

Employer: _____ **Risk No.** _____

☐ INJURY CERTIFIED BODY PART: _____

☐ REJECTED REASON FOR REJECTION: _____

_____

Signature, Authorized Workers' Comp Rep Date

Accident Report Revised 4/20/12