EMPLOYEE ACCIDENT/INCIDENT REPORT FORM

Part A. Information on All Accidents/Incidents

1. Name: _____ Position: _____

2. Department: _____ Date of Birth: _____ Sex: M ☐ F ☐

3. Date: _____ Time of Occurrence: _____ AM _____ PM

4. Location of Incident: _____

5. Nature of Injury

Abrasion	☐	Burn/Scald	☐
Amputation	☐	Cut/Laceration	☐
Asphyxiation	☐	Poisoning	☐
Bite	☐	Puncture	☐
Brake	☐	Scratches	☐
Bruise	☐		
Other _____			

6. Part of Body Injured

Abdomen	☐	Face	☐	Neck	☐
Ankle	☐	Finger	☐	Nose	☐
Arm	☐	Foot	☐	Scalp	☐
Back	☐	Hand	☐	Shoulder	☐
Chest	☐	Head	☐	Toe	☐
Ear	☐	Knee	☐	Tooth	☐
Elbow	☐	Leg	☐	Wrist	☐
Eye	☐	Mouth	☐	Left ☐ Right ☐	
Other _____					

7. Description of Accident: How did it happen? What was the employee doing? (List specifically unsafe acts unsafe conditions existing. Specify any tool, machine, equipment or vehicle involved.)

_____

_____

_____

_____

_____

8. Were there other employees involved in this incident? If yes, please give their name and injuries (if any).

Staff Involved: 1. _____ Injuries _____

2. _____ Injuries _____

Witnesses: 1. _____ Phone No: _____

2. _____ Phone No: _____

10. Immediate Action Taken

First-Aid Treatment (treatment/name): _____

Sent Home (Yes/No/Name): _____

Sent to Physician (By Name): _____

Physician's Name: _____

Sent to Hospital (By Name): _____

Name of Hospital: _____ Date & Time: _____

11. Was it necessary to notify employee's family? Yes ☐ No ☐ If yes, name of individual contacted:

Name: _____ Date: _____ Time: _____

12. Comments: (What recommendations do you have for preventing other accidents of this type)? _____

_____

_____

_____ _____

Employee Signature Date Supervisor Signature Date

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SUPERVISOR'S ACCIDENT/INCIDENT INVESTIGATION REPORT

Part B. Follow-up Information on All Accidents/Incidents

1. Name: _____ Hire Date: _____
2. Type of Incident: _____
3. Total number of days lost from work? _____ Days on Light Duty: _____
4. Degree of Injury: Death Permanent Impairment Temporary Disability Nondisabling
5. Treatment Received: _____
6. Witness Statements attached? Yes ☐ No ☐ Drug screening Completed (if required)? _____
7. Were Photographs or Video Taken? Yes ☐ No ☐ Attached: Yes ☐ No ☐
8. Met with employee: Yes ☐ No ☐ (If Yes give a brief summary of discussion.)

_____

_____

_____

_____

_____

19. Do you feel that any process or procedures could be changed to prevent this type of incident from occurring again? If yes, actions taken for prevention? _____

_____

_____

Date of Last Service: _____

Were safeguards or safety equipment provided & in place? _____ Was the equipment used? _____

20. Vehicle Involved (If Applicable): Vehicle Make/Model: _____

Did the incident involve vehicle damage: Yes ☐ No ☐ (If yes, complete below)

Were the Police Notified? Yes ☐ No ☐ Report Number: _____

Vin Number: _____

_____

Supervisor's Signature Date

For Internal Use Only:

Date Claim Reported: _____ Name of Representative: _____

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