

Employee Accident Report Form

Please print clearly. This report must be submitted within 24 hours of injury/illness to the Human Resource Office.

Claim Information

Injured Employee's Name:

Home Address:

(Street)

(City)

(State)

(Zip)

Home Phone:

Gender: ☐ Male ☐ Female

Date of Birth:

Occupation:

Department Name:

Supervisor's Name

Supervisor's Phone Number:

Date of Injury:

Time of Injury:

☐ AM ☐ PM

Time Workday Began:

☐ AM ☐ PM

Did the accident occur at the work location: ☐ Yes ☐ No Which building:

If no, where did the accident occur?

(Street)

(City)

(State)

(Zip)

Give a full description of how the accident occurred.

Date and time reported to employer:

Person injury reported to:

Injury Description:

Date of Death (if applicable):

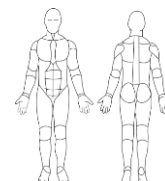
Is Employee Hospitalized: ☐ Yes ☐ No

Which part of the body was injured? (Please shade in the area on the body diagram to the right)

☐ Neck ☐ Upper Back ☐ Lower Back ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Leg ☐ Knee ☐ Ankle ☐ Foot
☐ Other _____

Part of body Location:

☐ Left ☐ Right ☐ Both



Has the employee lost time? ☐ Yes ☐ No

If yes, when was the first full day out?

Medical Information

Initial Medical Treatment:

Medical Treatment: ☐ Yes ☐ No

Refused to see Doctor: ☐ Yes ☐ No

Minor/Onsite First Aid: ☐ Yes ☐ No

Physician/Clinic: ☐ Yes ☐ No

ER Treated and Released: ☐ Yes ☐ No

Hospitalized: ☐ Yes ☐ No

Clinic/Doctor: **Complete only if employee was treated at clinic**

(Name of Clinic/Doctor)

(Address)

(Phone Number)

Hospital: **Complete only if employee was treated at hospital**

(Name of Hospital)

(Address)

(Phone Number)

Witness Information

Were there any witnesses? ☐ Yes ☐ No

If yes, list names and how to contact them:

Comments

Employee Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____