

EMPLOYEE REPORT of ACCIDENT/INJURY

The employee must complete this report as soon as possible following an accident/injury. This report will be provided to the supervisor within 24 hours of the accident/injury.

Name: _____		Date of Injury: _____		Time of Injury: _____		AM PM	
Social Security # _____		Date of Birth: _____		Work Phone # _____		Home Phone # _____	
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		Date Employed: _____		Dept/Div: _____			
Home Address: _____							
Shift: A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>		Start Time of Work Day: _____		: _____		AM PM	
Witnesses (attach statement for each)							
Name: _____		Title: _____		Phone Number: _____			
Name: _____		Title: _____		Phone Number: _____			
Name: _____		Title: _____		Phone Number: _____			
Exact Location Injury Occurred: _____				Duties Being Performed: _____			
Describe the circumstances causing the injury:							
Personal Protection Equipment Used:							
<input type="checkbox"/> Foot Protection.		<input type="checkbox"/> Face/Eye Protection.		<input type="checkbox"/> Fall Protection.		<input type="checkbox"/> Respiratory Protection.	
<input type="checkbox"/> Hand Protection.		<input type="checkbox"/> Head Prot.		<input type="checkbox"/> Apron/Chaps		<input type="checkbox"/> Back Belt	
<input type="checkbox"/> None		<input type="checkbox"/> Lifting Assistance Device					
<input type="checkbox"/> Other: _____ Object, equipment, or substance, which caused injury: _____							
Choose factor (s), which directly or indirectly caused the accident to occur:							
<input type="checkbox"/> Struck by Flying/Thrown Object		<input type="checkbox"/> Caught in/Under/Between Objects		<input type="checkbox"/> Temperature Extremes			
<input type="checkbox"/> A Fall		<input type="checkbox"/> Struck by an Object/Person		<input type="checkbox"/> Rubbed or Abraded by Object			
<input type="checkbox"/> Bodily Reaction		<input type="checkbox"/> Electric Shock		<input type="checkbox"/> Struck Against Object			
<input type="checkbox"/> Blood/Fluid Exposure		<input type="checkbox"/> Other Disease Exposure		<input type="checkbox"/> Noise Exposure			
<input type="checkbox"/> Vehicle/Equipment Accident		<input type="checkbox"/> Toxic Material Exposure		<input type="checkbox"/> Repetitive Motion			
<input type="checkbox"/> Client Caused		<input type="checkbox"/> Client Assault		<input type="checkbox"/> Other-Describe			
Nature of Injury:							
<input type="checkbox"/> Head		<input type="checkbox"/> Trunk		<input type="checkbox"/> Digestive		<input type="checkbox"/> Eye (s) R L B	
<input type="checkbox"/> Neck		<input type="checkbox"/> Abdomen		<input type="checkbox"/> Respiratory		<input type="checkbox"/> Shoulder(s) R L B	
<input type="checkbox"/> Chest		<input type="checkbox"/> Groin		<input type="checkbox"/> Circulatory		<input type="checkbox"/> Arm (s) R L B	
<input type="checkbox"/> Back		<input type="checkbox"/> Skin		<input type="checkbox"/> Hand (s) R L B		<input type="checkbox"/> Wrist(s) R L B	
						<input type="checkbox"/> Ankle(s) R L B	
						<input type="checkbox"/> Finger(s) T I M R P	
						<input type="checkbox"/> Foot/Feet R L B	
						<input type="checkbox"/> Hip(s) R L B	
						<input type="checkbox"/> Toe(s) R L B	
						<input type="checkbox"/> Other-Describe:	
Medical Treatment:							
<input type="checkbox"/> No Treatment		<input type="checkbox"/> First Aid		<input type="checkbox"/> Employee Health Clinic		<input type="checkbox"/> Outside Medical Treatment	
Employee's Signature: _____				Title: _____		Date: _____	
Supervisor's Signature: _____				Title: _____		Date: _____	

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