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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 #** _____

☐ **Full Time** ☐ **Part Time** **Date Employed:** _____ **Dept/Div:** _____

Home Address: _____

Shift: A ☐ **B** ☐ **C** ☐ **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:

☐ **Foot Protection.** ☐ **Face/Eye Protection.** ☐ **Fall Protection.** ☐ **Respiratory Protection.** ☐ **Hand Protection.**

☐ **Head Prot.** ☐ **Apron/Chaps** ☐ **Back Belt** ☐ **None** ☐ **Lifting Assistance Device**

☐ **Other:** **Object, equipment, or substance, which caused injury:**

Choose factor (s), which directly or indirectly caused the accident to occur:

☐ **Struck by Flying/Thrown Object** ☐ **Caught in/Under/Between Objects** ☐ **Temperature Extremes**

☐ **A Fall** ☐ **Struck by an Object/Person** ☐ **Rubbed or Abraded by Object**

☐ **Bodily Reaction** ☐ **Electric Shock** ☐ **Struck Against Object**

☐ **Blood/Fluid Exposure** ☐ **Other Disease Exposure** ☐ **Noise Exposure**

☐ **Vehicle/Equipment Accident** ☐ **Toxic Material Exposure** ☐ **Repetitive Motion**

☐ **Client Caused** ☐ **Client Assault** ☐ **Other-Describe**

Nature of Injury:

☐ **Head** ☐ **Trunk** ☐ **Digestive** ☐ **Eye (s) R L B** ☐ **Wrist(s) R L B** ☐ **Ankle(S) R L B**

☐ **Neck** ☐ **Abdomen** ☐ **Respiratory** ☐ **Shoulder(s) R L B** ☐ **Finger(s) T I M R P** ☐ **Foot/Feet R L B**

☐ **Chest** ☐ **Groin** ☐ **Circulatory** ☐ **Arm (s) R L B** ☐ **Hip(s) R L B** ☐ **Toe(s) R L B**

☐ **Back** ☐ **Skin** ☐ **Hand (s) R L B** ☐ **Other-Describe:**

Medical Treatment:

☐ **No Treatment** ☐ **First Aid** ☐ **Employee Health Clinic** ☐ **Outside Medical Treatment**

Employee's Signature: _____ **Title:** **Date:**

Supervisor's Signature: **Title:** **Date:**

Distribution:
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