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:

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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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