

ACCIDENT/INJURY REPORT

Date: _____

Name: _____ Soc. Sec. No.: _____ Birth Date: _____

Home Address: _____

Home Phone: _____ Sex: Male Female Marital Status: _____

Department: _____ Job Title: _____

Location of accident: _____ Date of accident: _____ Date reported: _____

_____ Time of accident: _____ Time reported: _____

Activity at time of injury (e.g. sweeping floor, lifting boxes): _____

Description of accident: _____

Identify any equipment/chemicals/materials in use: _____

Type of injury (e.g. cut, sprain, burn): _____

Body part affected (e.g. head, lower back, right arm): _____

Treatment provided: Yes No If yes, by whom: _____

Provider Name/Address

Date first treated: _____

Time lost: Yes No First day of lost time: _____ Day returned to work: _____

Witness Name and Department: _____

Witness Name and Department: _____