Accident / Injury Report

Employee's Report

(To be filled out **immediately** for all occupational injuries or illnesses)

Employee Name: ____

Job Title: ____

Date & Time of Injury: ____

Did this incident occur on company property? (please circle one) YES / NO

Name of person whom incident was reported to: ____________________________________

Name of witnesses: ____

Summarize what happened in your own words: ______________________________________

____

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What could have been done to avoid this accident? __________________________________

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____

What part of your body was injured? Describe in detail & be specific. ____________________

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Is this a new injury or a re-injury? ____

If a re-injury, when and where did original injury occur? ______________________________

Date and time medical attention was sought: ______________________________________

Doctor Seen: ____________________________ **Office/Hospital:** ________________________

Employee Signature: ______________________________________ **Date:** ____________________