

EMPLOYEE ACCIDENT REPORT
Supplementary Record of Occupational Injuries and Illness

INJURED OR ILL EMPLOYEE

1. Name: _____ Social Security No.: _____
(First Name) (Middle Name) (Last Name)

2. Home Address: _____
(No. and Street) (City or Town) (State)

3. Age: _____ 4. Sex: M F (check one) Date of Birth: _____

5. Occupation: _____
(Enter regular job title, not the specific activity (s)he was performing at time of injury)

6. Assigned Work Location: _____
(Enter name of location in which the injured person is regularly employed, even though (s)he may have been temporarily working in another location at the time of injury.)

THE ACCIDENT OR EXPOSURE TO OCCUPATIONAL ILLNESS

7. Place of accident or exposure: _____
(No. and Street) (City or Town) (State)

If accident or exposure occurred on employer's premises, give address of establishment in which is occurred. If accident occurred outside employer's premises at an identifiable address, give that address. If it occurred on a public highway or at any other place, which cannot be identified by number and street, please provide place references locating the place of injury as accurately as possible.

8. Was the place of accident or exposure on employer's premises? Yes No

9. What was the employee doing when injured? _____

(Be specific, if (s)he was using tools or equipment or handling material, name them and tell what (s)he was doing with them.)

10. How did the accident occur? _____

(Describe fully the events that resulted in the injury or occupational illness. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors that led or contributed to the accident. Use separate sheet for additional space.)

OCCUPATIONAL INJURY OR OCCUPATIONAL ILLNESS

11. Describe the injury or illness in detail and indicate the part of body affected: _____

(e.g.: amputation of right index finger at second joint; fracture of ribs; lead poisoning; dermatitis of left hand, etc.)

12. Name the object of substance that directly injured the employee. (For example, the machine or thing (s)he struck against or which struck him/her; the vapor or poison he inhaled or swallowed; the chemical or radiation which irritated his/her skin; or in cases of strains, hernias, etc., the thing (s)he was lifting, pulling, etc.)

13. Date of injury or initial diagnosis or occupational illness: _____
(Date)

14. ESTIMATED LOST TIME FROM WORK: _____

15. Did employee die? Yes No

16. Did employee receive Doctor's treatment? Yes No

17. Type of treatment given to employee for the injury (not necessarily by doctor) _____

18. Name and address of physician: _____

19. If hospitalized, name and address of hospital: _____
Date of report: _____ Prepared by: _____
Official position: _____

Administrator Signature: _____