



ACCIDENT REPORT

Name of Injured Person:		Social Security #:	
Date of Accident:	Time:	<input type="checkbox"/> am <input type="checkbox"/> pm	Phone#:
Location of Accident:			
Area or Department where the accident happened:			
Full-time <input type="checkbox"/>	Part-time <input type="checkbox"/>	Temporary <input type="checkbox"/>	Student Worker <input type="checkbox"/> Occupation:
Typical work shift at time of accident: Starting Time:		<input type="checkbox"/> am <input type="checkbox"/> pm	Ending Time: <input type="checkbox"/> am <input type="checkbox"/> pm
Last Day Worked :	Did the injury result in disability beyond the date of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the person returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Date returned :	Time:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
How did the accident or injury happen?			
Describe the injury or illness:			
Part (s) of the body injured:			
Unsafe act causing the accident, if known:			
Unsafe condition (s) causing the accident, if known:			
Action taken to prevent similar accident:			
Recommendations of additional action beyond your resources:			
List witnesses:	Was first aid given? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If this is a first-aid report and the person was not sent to doctor check here. <input type="checkbox"/>			
Name and address of doctor:			
Name and address of Hospital:			
Supervisor directly responsible for employee:			
Signature of Employee:			Date:
Signature of Employer Representative:			Date:

