Accident Report Form - Employees

<table>
<tr><td colspan="4">Employee Full Name:

Name of Temporary Employee Agency (if applicable):</td><td colspan="2">Employee Date of Birth:</td></tr>
<tr><td colspan="3">Job Position/Title:</td><td colspan="3">Supervisor:</td></tr>
<tr><td>Date of Incident:</td><td colspan="2">Time of Incident:
AM/PM</td><td colspan="2">Workday began:
AM/PM</td><td>Location/Jobsite:</td></tr>
<tr><td colspan="2">To Whom Reported:</td><td colspan="2">Date Reported:</td><td colspan="2">Time Reported:
AM/PM</td></tr>
<tr><td colspan="2">Employee Address:</td><td colspan="2">City/State/Zip:</td><td colspan="2">Phone number:</td></tr>
</table>

Describe how the accident happened: (What you were doing when your accident occurred?)

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Name(s) of all witness(es): ______________________________

What Personal Protective Equipment were you wearing? ______________________________

Were safety policies and procedures being followed? ☐ YES ☐ NO Explain: ______________

What part(s) of your body did you injure? ______________________________

Was First Aid administered? ☐ YES By whom?______________________________

☐ NO Why?______________________________

Did you notify your manager? ☐ YES Date: ______________Time:______________

☐ NO Why? ______________________________

Was additional medical attention required? ☐ YES List the attending physician, location, and name of treatment facility: ______________________________

☐ NO

In your opinion, what should be done to prevent injuries of this type from occurring again?

____

EMPLOYEE STATEMENT: The facts as I have stated them are true to the best of my knowledge.

______________________________ ______________

Signature of Employee Date