EMPLOYEE'S REPORT OF ACCIDENT / INCIDENT

To be completed by the **employee** involved

Name: ______________________________________ Social Security #: _____________________________

Address:_____________________________________ Phone Number:________________________________

_____________________________________ Birth date:____________________________________

_____________________________________ Number of Dependents:________________________

Sex: ___________ Age: ___________ (Married) (Single) (Divorced) (Widowed)

Employment Start Date: _________________ Do you have another job?________ Hours:________________

If yes, where? ____

Date of Accident: ______________________________ Time of Day: __________________ AM PM

Where did it happen? ____

What job or activity were you doing when the accident happened?

____

Did anyone else see it? __________________ Who? ____

Exactly how did the accident happen? ____

____

____

____

What caused the accident? ____

____

What could have prevented it from happening? ____

____

____

Exactly what part(s) of your body got hurt? (Tell whether **Left** or **Right**) ______________________

____

How bad did this feel at the time?____

Have you ever had an injury to this part of your body before? ______________ If so, when?______________

What happened?____

____

Did it happen off work, or working? _____________ (if working) Who were you working for?____________

____

Is there any work or activity that you thing you can't do now? ________________________________

Did you notify your Supervisor right away?______________ Were you sent to the doctor?______________

Who was the doctor?_____________________________ What clinic or hospital?____________________

_____________________________ ____________________

_____________________________ ____________________

Your Signature: ________________________________ Date: ___________________________