ACCIDENT / INJURY REPORT

Date:_____ **Department:**_____

Name:_____

Address:_____
Street **City** **State** **ZIP**

Home Phone:_____ **Work Phone:**_____

Sex_____ **Date of Birth:**_____ **Job Title:**_____

Date of Accident/Injury:_____ **Time of Accident Injury:**_____ **AM / PM**

Reported to:_____

Name of Supervisor:_____

Where did Accident/Injury Occur (Exact Location):
_____

Describe in Detail how injury occurred: _____
_____
_____

Part(s) of Body Injured: _____

Was medical treatment sought?_____ **If Yes, give physician name and address:**
_____
_____

Did you return to work:_____ **If yes, give date and time of return:** _____
_____

Physician / Nurse comments:_____
_____
_____

Employee Signature:_____ **Date:**_____