

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: _____