**ACCIDENT/INJURY REPORT**

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| --- | --- | --- |
| Employee Name | Street Address | City, State, Zip (Postcode) |
|  |  |  |
| Employee Hire Date | Employee Phone # | Friend/Relative Name and Phone # |
| Employee Department | Office Location | Are there other employees who do the same job? [ ] Yes [ ] No |
| Does the employee speak English?  [ ] Yes [ ] No | If not, what language does the employee speak?  |
| Date and Time of Accident: AM/PM | Was the employee paid for the full day?[ ] Yes [ ] No | Date you were first aware of the accident |
| Manager / Director Name and Phone # | Medical Facility | City, State, Zip (Postcode) |
|  |  |  |
| Was Employee treated at the Emergency Room  [ ] Yes [ ] No | Was Employee hospitalized overnight? [ ] Yes [ ] No |
| Description, extent of injuries, and body part affected |
| What was the employee doing at the time of accident and how did it occur? |
| Address and/or location where accident occurred |
| Machine, tool, or object that caused the injury |
| Safety equipment or instruction provided? | Was it being used? [ ] Yes [ ] No |
| If this was an MVA, was the employee wearing a seat belt? [ ] Yes [ ] No | Was a police report filed? [ ] Yes [ ] No | Were citations issued? [ ] Yes [ ] No |
| Witness Name and Phone # | Street Address | City, State, Zip (Postcode) |
| **Injured Employee Signature** | **Date** |
| **MANAGER / DIRECTOR ONLY** |
| Do you agree with the description given in the above report? [ ] Yes [ ] No |
| If no, please give the reason |
| Corrective action(s) taken |
| **Manager / Director Signature** | **Date** |

*Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.*