**Part I: Injured Employee Information**

**Date of Hire: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Name of Employee (Last, First Middle):**  | **Phone Number: (H):** **(W):****(C):** | **Sex**:[ ]  Male[ ]  Female |
| **Address:** | **Date of Birth:** | **Marital Status**:[ ]  Single[ ]  Married[ ]  Divorced[ ]  Widowed**# of dependent children**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Social Security Number:**  |
| **City/County and Zip Code where the accident Occurred:** | **Date of Injury:** | **Hour of injury:**\_\_\_\_\_\_\_\_\_AM/PM |
| **Time Work Began:**  **\_\_\_\_\_\_\_\_\_\_AM/PM** |
| **Date/injury or illness reported:** | **Person to whom reported:** | **Name of witness:** |
| **Employee’s Description of Accident (i.e. Describe machine, tool, or object causing injury or illness and describe fully how the incident occurred):** |
| **Injury Information (i.e. description of injury (burn, bruise, etc.):**  |
| **I certify that the information provided above is true and complete.****Employee Signature:** | **Date:** |

**Part II: Supervisor’s Investigation of the Incident**:

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| **Describe any UNSAFE Acts:** |
| **Describe any UNSAFE Conditions:** |
| **Identify the Cause(s) of the Accident:** |
| **Corrective Action Taken:** |
| **Has it been done? If not, give reason.** |
| **Was the accident/injury suspicious in nature? If so, please describe.** |
| **Was the Panel of Physician’s List Provided to the Employee?** [ ]  Yes- Attach a copy to this report [ ]  No (explain why) |
| **I certify that the information provided above is true and complete.****Supervisor’s Signature:** | **Date:** |

**Part III: Accident Analysis Details:**

**Severity of Injury/Damage**:

🞏 Fatality 🞏 Lost Workdays 🞏 Medical Treatment (off premises) 🞏 First Aid (On site)
🞏 Significant Property Damage

**Employment Category**:

🞏 Regular, Full-time 🞏 Regular, Part-time 🞏 Temporary 🞏 Contractor 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Time in Occupation at the time of the accident:**

🞏 Less than 6 months 🞏6 months to 2 years 🞏 2 to 5 years 🞏 More than 5 years

**Work Shift at the time of the accident:**

🞏 Day Shift 🞏Evening Shift 🞏 Night Shift

|  |  |  |
| --- | --- | --- |
| Prepared by: (Name & Title)  | Work Phone #:  | Date Report Prepared: |
| Reviewed by: (Name & Title) | Work Phone #: | Date Report Reviewed: |

**Follow – up Action:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_