Accident/Illness Report

Employer Information:

Prepared by: _____ Job Title: _____ Date of this Report _____

Date of Accident/Illness Reported to Preparer: _____ Work Site/Location: _____

Time Reported to Preparer: _____

Employee Information:

Name: _____ Job Title: _____

LAST FIRST MIDDLE

Home Address: _____ City:_____ State: _____ Zip: _____

Phone: _____ Gender: □ Female □ Male Date of Birth: _____

Social Security Last 4 #r: _____

Facts of Accident/Illness:

□ Illness □ Injury □ Fatality? Date of Accident/Illness: _____

Did accident cause loss of time beyond normal shift? □ Yes □ No Time of Accident/Illness: _____

Date Employee first lost time due to Accident: _____

Time Employee first lost time due to Accident: _____

Note: if fatality occurred or more than 3 employees are hospitalized, OSHA must be notified within 8 hours.

Exact Location of Accident: _____

What was employee doing when the accident or exposure occurred? (Be specific. If employee was using tools or equipment or handling material, name them and tell what employee was doing with them.)

_____

_____

_____

_____

Explain how the incident occurred. List events that resulted in injury or illness, what happened, how it happened and name objects and how they were involved (use separate sheet if necessary.)

_____

_____

_____

_____

Describe the specific cause of the injury or illness.

_____

_____

_____

_____

Nature of Accident/Illness:

Describe injury/illness and indicate the part of the body affected (e.g. amputation of _____, burn on left ring finger, etc).

_____

_____

_____

_____

Name object or substance which directly injured employee. _____

Witness Information:

1. Name: _____ Phone: _____

   Address: _____ City: _____ State: _____ Zip: _____

2. Name: _____ Phone: _____

   Address: _____ City: _____ State: _____ Zip: _____

Medical Attention:

□ First Aid given by: _____ Date: _____ Time: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

□ Doctor's Name: _____ Date: _____ Time: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

□ Hospital Name: _____ Date: _____ Time: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

□ Released □ Admitted □ Anticipated length of hospital stay: _____

Notification:

Family notified by: _____

	Yes	No	Date
Notified Personnel Department?	□	□	_____
Notified State Workers' Compensation Agency?	□	□	_____
Notified Employers' Workers' Compensation carrier?	□	□	_____
Has the cause of accident been corrected?	□	□	_____

Describe future action to be taken, including preventive measures to ensure the accident does not occur again.

_____

_____

_____

_____

Approved by: _____ Date: _____

Supervisor on duty: _____ Date: _____