## **Employee Report of Accident, Injury or Illness**

Instructions: Please Print. Fill in all blanks. If a blank does not pertain to your accident, injury or illness write "N/A" in that blank. When completed, return this form to your supervisor.

Name:		
(Last)	(First) (Middle Initial)	
Social Security Number: (last 4 digits)	Sex: Date of Birth:	
Address:		
	ity) (State) (Zip)	
Martial Status: Single Married Sepa	rated Divorced Widowed	
Telephone Number:	Email address:	
Employment Start Date:	Time in Present Job:	
Job Title:	Supervisor's Name:	
Department:	Date & Time of Accident:	
Location of Accident:	Task Being Performed:	
Name of Witness:	Name of Witness:	
Date & Time you first sought medical attention:		
Are you seeking medical treatment today: 🔲 Y	es No *if no, complete waiver on last page	
Name of Hospital or Doctor:		
Do you have a job at another company?		
Describe how the accident happened and what body part injured?		
What caused the accident?		
The information I have provided either in my own writing or verbally for the purpose of this form is true and correct. I understand that providing false or misleading information or omission of information on this report or any other form relating to this claim of injury/accident may result in termination of my employment. By signing this accident form, I hereby authorize any and all medical providers to discuss my work related condition and provide all medical documentation.		
SIGNATURE OF EMPLOYEE:	DATE:	

## **Supervisor's Report of Accident**

Basic Rules for Accident Investigation

- Find the cause to prevent future accidents-Use an unbiased approach during investigation
- Interview witness & injured employees at the scene-conduct a walkthrough of the accident
- Conduct interviews in private-interviewed one witness at a time.
- Get signed statements from all involved.
- Take photos or make a sketch of the accident scene
- What hazards are present what unsafe acts contributed to accident
- Ensure hazardous conditions are corrected immediately.

Date & Time:	Location:	
Task performed:	Witness:	
Resulted in:   Injury   Illiness	Fatality Property Damaged	
Describe Accident Facts & Events and what	body part injured:	
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Supervisor's Root Cause Analysis Check ALL that apply to this accident		
Check ALL man apply to this accident		
UNSAFE ACTS:	UNSAFE CONDITIONS:	
☐ Improper work technique	Poor workstation design	
Safety rule violation	Unsafe operation method	
Improper PPE or PPE not used	☐ Improper maintenance	
Operating without authority	Lack of direct supervision	
Failure to warn or secure	☐ Insufficient training	
Operating at improper speeds	Lack of experience	
Bypassing safety devices	Insufficient knowledge of job	
Improper loading or placement	Slippery conditions	
Improper lifting	Excessive noise	
Servicing machinery in motion	Defective tools/equipment	
Horseplay	Poor housekeeping	
Drug or alcohol use	☐ Inadequate guarding of hazards	
Supervisor's Signature:		
UNSAFE ACTS REQUIRE A WRITTEN WARNING AND RE-TRAINING BEFORE THE EMPLOYEE RESUMES WORK		
Re-Training Assigned Date:	Unsafe Condition Guarded Date:	
Re-Training Complete Date:	Unsafe Condition Corrected Date:	

## REFUSAL OF MEDICAL TREATMENT WORKERS' COMPENSATION

I,	, hereby acknowledge that my supervisor(s) has
offered and made available to me an op	oportunity to seek necessary medical treatment and/or
observation at the expense of my emplo	oyer,, for the
work-related injury I incurred on	I am voluntarily
choosing to decline medical treatment a	and/or observation at this time.
I understand that I may request from m	y employer, at a later time, authorization to obtain
medical treatment and/or observation for	or the injury described above. However, I understand that
my refusal of medical treatment and/or	observation today may impact my eligibility for workers'
compensation benefits related to the inj	jury described above.
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Employee Signature	Date
Witness Signature	Date