Accident and Incident Report
Employee

SECTION 1: EMPLOYEE INFORMATION (all fields required)

First Name	M.I.	Last Name		SSN
Street		City	State	Zip
Home/Cell Phone		Date of Birth	Gender	Marital Status

Job Title	Department		Date of Hire
Hours Worked per Day	Days Worked per Week	Hours Worked per Week	Hourly Wage/Annual Salary

SECTION 2: ACCIDENT & INJURY INFORMATION (provide as much detail as possible)

Date of Accident	Time of Accident	Location of Accident

Explain the accident. How did it occur? What activity was the employee engaged in when the accident occurred? Please be specific and provide as many details as possible.

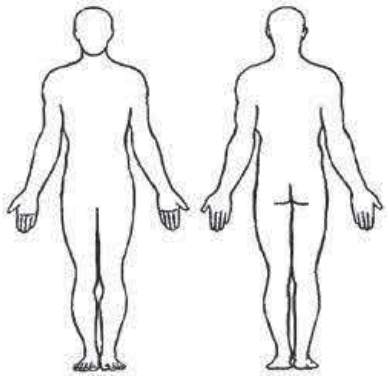
What object or substance caused the injury or directly harmed the employee?	What equipment was being used at the time of accident?
Who did the employee report the accident to?	When was the accident reported?
Witness Name(s)	Witness Phone Number(s)

Type of Injury or Illness
Did the employee seek medical treatment?
If yes, where was the medical treatment provided?
Date and Time of Treatment
Did the employee leave work early on the day of the accident?
Did the employee miss time from work?
If yes, how many days did the employee miss?
Date Employee Returned to Work

Body part(s) affected/injured (circle on diagram)

	L	R
Eyes/Ears/Face	☐	☐
Neck/Shoulders/Arms/Elbows	☐	☐
Hips/Legs/Knees	☐	☐
Wrist/Hands/Fingers	☐	☐
Ankles/Feet/Toes	☐	☐
Back (Upper/Lower)	☐	
Head	☐	
Internal Organs	☐	

Other: _____



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If the employee was unable to complete this form, who completed it on his or her behalf?

Employee Signature	**Date**