Office of Human Resources

Accident & Injury Report

ALL PAGES OF THIS REPORT MUST BE COMPLETED BY THE SUPERVISOR, DEPARTMENT HEAD, OR DEPARTMENT RISK MANAGER, AND FORWARDED TO THE OFFICE OF HURMAN RESOURCES WITHIN 24 HOURS. ALL INJURIES MUST BE REPORTED.

Date of Injury: _____ Employee Name:_____

Employee SSN: _____ Employee Date of Birth: _____ Employee Sex: ☐ Male ☐ Female

Rate of Pay (Hourly): $_____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Date of Employment: _____ Department: _____ Position Title: _____

Employee Home Address: _____

_____

City: _____ State: _____ Zip Code: _____

Employee Home Phone Number: _____ Employee Work Phone Number: _____

Time of Injury: (HH:MM am/pm) _____ Last Day worked: _____ Number of Days Worked Per Week: _____

Location of Accident: _____

Was accident on Employer's premises? ☐ YES ☐ NO

Witnesses Name and Phone Numbers:

Check the box which best describes the type of injury incurred:

☐ Amputation	☐ Cut (laceration, abrasion)	☐ Foreign Body (specify) _____
☐ Burn (heat, chemical)	☐ Dermatitis (skin rash)	☐ Fracture
☐ Concussion or Paralysis	☐ Electrical Shock	☐ Poisoning (specify) _____
☐ Contusion/Bruises	☐ Exposure Only (specify) _____	☐ Sprain/Strain/Dislocation

Other (Specify):

Additional Information Regarding Type of Injury:

Other Medical Information

☐ Medical Attention Date: _____ ☐ Physician Name: _____

☐ Hospital/Medical Facility Name: _____ ☐ First Aid (specify): _____

☐ Fatality: ☐ YES ☐ NO / Date:

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Check the box which best describes the Area of Injury:

☐ Head	☐ Hand/Wrist -- ☐ Left ☐ Right	☐ Hip -- ☐ Left ☐ Right
☐ Facial	☐ Arm/Elbow -- ☐ Left ☐ Right	☐ Leg/Knee -- ☐ Left ☐ Right
☐ Neck	☐ Finger -- ☐ Left ☐ Right	☐ Ankle/Foot -- ☐ Left ☐ Right
☐ Eye -- ☐ Left ☐ Right	☐ Shoulder -- ☐ Left ☐ Right	☐ Toe -- ☐ Left ☐ Right
☐ Ear -- ☐ Left ☐ Right	☐ Back/Spine	☐ Chest (ribs/Internal Organs)
☐ Mouth/Teeth	☐ Urological/Genital/Pelvis	☐ Abdomen (including Internal Organs)
☐ Other (specify):		

Additional Information Regarding Area of Injury:

Describe clearly and briefly how the accident occurred:

Employee Name: _____

Employee Signature: _____ **Date:** _____

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1. **Do you anticipate this employee losing time from work due to this injury?** ☐ YES ☐ NO (Do not include the day of the accident.)

2. **Do you anticipate this employee incurring temporary disability (unable to perform regular duties from the injury they sustained from this incident)?** ☐ YES ☐ NO

3. **Does this employee work a shift schedule?** ☐ YES ☐ NO

   If yes, what is the date of their next scheduled work day? _____

4. **What acts, failures to act, and/or conditions contributed most directly to this accident?**

5. **What safety equipment provided to the employee could have prevented or lessened the impact of this accident?**

   Was the employee using this safety equipment at the time of this accident? ☐ YES ☐ NO

6. **What action has, or will be taken, to prevent reoccurrence?**

Supervisor Signature: _____ **Date:** _____

Department Head Signature: _____ **Date:** _____

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BODY PART CHART

Employee Name: _____ **Date of Accident:** _____

Employee Signature: _____ **Date:** _____ _____

Reported By: _____ **Date of Report:** _____

Instructions: Please mark the injured body part and have the employee initial beside the part.