

Accident Report

TO BE COMPLETED BY INJURED EMPLOYEE: Date: _____

Name: _____ Social Security Number _____

Address (Street) _____ City _____ State _____ Zip _____

Telephone _____ Age _____ Sex _____ Birth Date _____

Job Title _____ Date started this title _____

Hourly Wage Rate _____ Department Where Injury Occurred _____

Were you doing your regular job? YES NO Supervisor's Name _____

Date of Injury _____ Time _____ a.m. p.m. Time Shift Started _____ a.m. p.m.

State fully what you were doing at time of injury and how injury occurred: _____

Nature and location of injury (Describe fully exact location of injury, right or left, etc.)

Was any other part of body injured? If yes, describe in detail: _____

Was First-Aid Given? YES NO (Describe) _____

Date you reported injury _____ Time _____ a.m. p.m. Reported to _____

Anyone else injured? If yes, Name(s): _____

Names(s), address & phone number of person(s) observing incident _____

Employee Signature _____ Date _____ Witness to signature _____

TO BE COMPLETED BY SUPERVISOR:

Was employee performing his/her regular job? YES NO (Describe) _____

Was employee properly instructed on safe job procedures? YES NO (Describe) _____

When did you first know of injury? Date _____ Time _____ a.m. p.m.

Where did the employee receive medical treatment? _____

When was the employee able to return to work? Date _____ Time _____ a.m. p.m.

<u>CAUSE OF INJURY</u>	<u>PROTECTIVE EQUIPMENT</u>	<u>REQUIRED</u>	<u>IN USE</u>
<input type="checkbox"/> Inattention to duties performed	Hard Hat	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Insufficient Instructions	Safety Glasses	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Improper Instructions	Dust Goggles	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Inadequate job planning	Full Face Shield	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lack of knowledge or skill	Respirator	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Improper use of equipment	Hearing Protection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fatigue	Welding Hood	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical disability	Cutting Goggles	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Uncooperative	Other (Describe) _____		

What was, defective, in unsafe condition, or wrong with method used? _____

What did employee do unsafely? _____

What could or should have been done to prevent injury? _____

What steps have been or will be taken to prevent similar injuries? _____

Was employee instructed to use any special protective equipment or safety procedure?
 YES NO (Describe) _____

Did employee follow these instructions, if provided? YES NO (Describe) _____

Was injury the result of failure of the employee to follow instructions or established safety rules?
 YES NO (Explain) _____

What action has been or will be taken because of this failure? (Describe) _____

Supervisor's Comments _____

Supervisor Signature _____ Date _____