EMPLOYEE ACCIDENT/INJURY REPORT

(To be completed by employee)

Name: _____
Last **First** **Middle**

Address: _____

Home Phone #: _____ **Work Phone #:**_____

Birth date: _____ **SS# :** _____ **Hire Date:**_____

Sex: **Female** ☐ **Male** ☐ **Marital Status:** **Married** ☐ **Widowed** ☐ **Single** ☐ **Divorced** ☐

Position Title: _____ **Work Location:** _____

Incident Occurred: **Date:** _____ **Time:** _____ **a.m.** _____ **p.m.**

Supervisor Notified: **Date:** _____ **Time:** _____ **a.m.** _____ **p.m.**

State in your own words how and where the incident occurred:

Describe injury/damage (indicate right or left side)

Do you require medical treatment: ☐ **Yes** ☐ **No** ☐ **Unknown/declined at this time**

Name (s) of Witnesses (if any):

Name (s) of others involved (if applicable):

Signature of Employee: _____ **Date:**