# Employee's Report of Injury Form

(To complete by the employee)

Employee's name: _____

__Male __Female Date of birth: ____/____/____ Home telephone :_____

Home address: _____

City: _____ State: Zip Code: _____

Present classification: _____

Location of accident: _____

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident):_____

_____

_____

_____

_____

Describe bodily injury sustained (be specific about body part(s) affected): _____

_____

Recommendation on how to prevent this accident from recurring: _____

_____

Name of supervisor: _____Contact #_____

Name(s) of witness(es): _____ Contact #_____

When did you report the accident to your supervisor? _____

Who did you report the injury to? _____

Do you require medical attention? Yes: _____ No: _____ Maybe: _____

Name of treating physician: _____Contact #_____

Signature of employee: _____Date: _____

# Accident Witness Statement

(To be completed by Accident Witness)

Injured employee's name: _____

Name of witness: _____ Phone # _____

Job title of witness: _____

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Location of accident: _____

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident): _____

_____

_____

_____

_____

Describe bodily injury sustained (be specific about body part(s) affected): _____

_____

_____

_____

Recommendation on how to prevent this accident from recurring: _____

_____

_____

Name of Witnesses Supervisor: _____ Phone: _____

Signature of Witness: _____ Date: _____

# Supervisor's Accident Investigation

(To be completed by the employee's supervisor or other responsible administrative official)

| | | |
|---|---|---|
| Location where accident occurred | Employer's Premises: Yes ☐ No ☐<br>Job site: Yes ☐ No ☐ | Date of accident or illness |
| Who was injured? | ☐ Employee<br>☐ Non-Employee | Time of accident ☐ a.m.<br>☐ p.m. |

| | | |
|---|---|---|
| Job title or occupation | Name of dept. normally assigned | How long has employee worked at job where injury or illness occurred? |
| What property/equipment was damaged? | | Property/equipment owned by: |

What was employee doing when injury/illness occurred? What machine or tool was being used? What type of operation?

How did injury/illness occur? List all objects and substances involved.

Part of body affected/injured?

Any prior physical conditions? If so, what?
Yes ☐ No ☐

Nature and extent of injury/illness and property damaged (be specific)

**PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS**

| | | |
|---|---|---|
| ____ Improper instruction | ____ Failure to lockout | ____ Unsafe arrangement or process |
| ____ Lack of training or skill | ____ Unsafe position | ____ Poor ventilation |
| ____ Operating without authority | ____ Improper dress | ____ Improper guarding |
| ____ Horseplay | ____ Improper protective equipment | ____ Improper maintenance |
| ____ Physical or mental impairment | ____ Unsafe equipment | ____ Inoperative safety device |
| ____ Failure to secure | ____ Poor housekeeping | ____ Other _____ |

Supervisor's corrective action to ensure this type of accident does not recur: _____

_____

_____

Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures?

Yes _____No _____

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures?

Yes _____ No _____

Did employee promptly report the injury/illness? Yes _____No_____

Is there modified duty available? Yes _____ No _____

Supervisor's name | Supervisor's Signature | Phone