

Accident Report



Date Filed _____

Facility / Job: _____

SS#: _____

Employee Name: _____

Phone: _____

Address: _____

Address2: _____

Address3: _____

City

State

Zip

Date of Birth: _____

Date of Injury: _____

Time of Injury: _____

Supervisor Name: _____

Witnesses: _____

Was proper Personal Protection Equipment worn at all times? Yes No

Describe Injury: _____

How did injury occur: _____

On Site Treatment: _____

Signature of Employee: _____ Date: _____

Signature of Supervisor: _____ Date: _____