Employee Accident Report

TO BE FILLED OUT BY EMPLOYEE

Name: ______________________________ Date: ______________

Occupation: ______________________ Is this your regular occupation? ❒ Yes ❒ No

Date of Accident: __________________ Time of Accident: _____ ❒ am ❒ pm

Where did accident occur? (exact location) ______________________________

How did accident happen? ______________________________

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Why did accident happen? ______________________________

Injury Type (Check One)				
	❒ Struck By	❒ Fall - Same Level	❒ Innhalation	❒ Contact w/Electricity
	❒ Struck Against	❒ Fall - Different Level	❒ Ingestion	❒ Strain/Sprain
	❒ Caught In/On	❒ Laceration	❒ Burn	❒ Fracture

Describe Injury, give detail: ______________________________

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Employee's Signature: ______________________________

TO BE FILLED OUT BY MANAGER

Date accident was first reported: ______________ To Whom: ______________

First Aid rendered? ❒ Yes ❒ No By Whom: ______________

Was outside medical attention given? ❒ Yes ❒ No Is Yes, Where: ______________

Did you investigate accident? ❒ Yes ❒ No Time Lost: ❒ Yes ❒ No How many days? ______

Were there any witnesses to the accident? ❒ Yes ❒ No If Yes, give full name and position: ______

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Have you changed any conditions or issued any instructions which will help to prevent recurrence? ❒ Yes ❒ No

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Do you have any suggestions for changes to avoid a similar accident? ❒ Yes ❒ No

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Manager's Signature: ______________________________ Date: ______________