

EMPLOYEE ACCIDENT REPORT

Employee Name: _____

Address: _____

Phone: _____

Job Title: _____ **Department:** _____

Date of Accident: _____ **Shift Start Time:** _____

Time of Accident: _____ **A.M.** _____ **or P.M.** _____

Supervisor: _____

Location of Accident: _____

Describe the Nature of the Injury: _____

Describe Exactly What Happened: _____

List Any Witnesses: _____

To Whom Did You Report the Accident/Injury? _____

What did you tell your Supervisor? _____

What did your Supervisor Do? _____

Employee Signature

Date

Please submit with First Report of Injury Form within 24 hours