Company Name
EMPLOYEE ACCIDENT REPORT

Please complete this form in full detail

Name _____ Age _____ Sex _____

Home Address _____

Occupation _____ Supervisor _____

Date of accident _____20_____ Time of Accident _____a.m. / p.m.

Was first aid applied? ___ yes ___ no

Who applied first aid to you? _____

(Example: myself or name of person and position)

Are you seeing a Doctor? ___ yes ___ no

Treating physician _____ _____ _____

(Name) (Address) (Date seen)

Where you admitted to hospital? ___ yes ___ no What hospital? _____

Name of witness(es) _____

Will you be away from work with this injury? ___ yes ___ no If yes how long? _____

Describe in detail how the accident happened?

_____

_____

_____

_____

_____ _____

Signature of person injured Signature of Manager/Supervisor

Date: _____20_____ Date: _____20_____

You must complete this form and report immediately before leaving work to your Manager.

FIRST COPY – COMPANY **SECOND COPY - EMPLOYEE**