ACCIDENT REPORT BY INJURED EMPLOYEE

Complete this form immediately after incident.

Employer: _____

Your Name: _____

Your Home Address: _____

Your Home Phone Number: _____ Weekly wage: _____

Social Security Number: _____ Date of Birth: _____

Date of Incident _____ Time _____ a.m. p.m.

In your own words, please describe what happened: _____

_____

_____

_____

What physical problems do you relate to this injury?

_____

_____

_____

Did you report this injury to your supervisor? _____ If not, why not? _____

Date Reported? _____ Supervisor's Name: _____

Were you working at your regular job at the time of the injury? _____ If not, explain:

_____

_____

_____

Were there any witnesses? _____ If yes, who? _____

_____

Did you go to the hospital/clinic? Yes: _____ No: _____

Address of hospital/clinic: _____

Name of treating physician: _____

Any additional comments: _____

_____

_____ _____

Date Signature