# Report of Accident

Date of Report ____________________ Date of Accident ____________________

Employer's Name ________________________________________

**Employee Information:** Name ________________________________________

Address (Home) ________________________________________

Date of Birth ____________________

Marital Status ______ Single _______Divorced ______Widowed ______ Separated

Occupation ____________________ Social Security Number ____________________

Telephone Number ____________________

**Injury Information** Nature and Extent of Injury ____________________

Description of Accident (Explain in Detail) ____________________

________________________________________

________________________________________

________________________________________

Time of Accident __________ When was the accident reported by employee ____________________

To whom was the accident reported to ________________________________________

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**Physician Information** Doctors Name and Address ____________________

________________________________________

________________________________________

Phone Number: ____________________

Date Employer quit work ____________________ Date expected to return ____________________

Do you expect the employee to be off more than 7 days? Yes ( ) NO ( )

Can employee continue his/her regular job after medical treatment (Doctor's advice)

Yes ( ) NO ( )

If the above answer is "No" can restricted work be provided within the employees limited physical capabilities in order to avoid time off from work. (Answer after consulting doctor at time of examination.) After first day – Yes ( ) NO ( ) After seven days – Yes ( ) NO ( )

If yes, describe new job ________________________________________

Did employee refuse to work at his/her regular job or the restricted position for him as approved by the doctor? Yes ( ) NO ( )

| ____________________ | ____________________ | ____________________ |
|---|---|---|
| Injured Worker | Printed Employee Name | Date |
| ____________________ | ____________________ | ____________________ |
| Employer Signature | Employer Printed Name | Date |

REPORT OF INCIDENT AT: ______________________________

## Section 1 - To be completed by employee

Date of Incident: ____________ Time: __________ AM/PM Date of Report: ______________

Employee's Name: ______________________________ SSN: ____________________
Last First M.I.

Home Address: ________________________________________________
Street City State Zip

Home Telephone: _________________________ Date of Birth: ____________________

Occupation: _____________________________ Regular Work Hours: From _____ To _____

Nature and Extent of Injury: (i.e.; cut left hand, sprain right knee, etc.) ______________________
________________________________________________________________

Description of Incident: (details of sequence of events leading up to incident) ______________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Did Employee seek Medical treatment? ______________ If so, when? ____________________

Medical Provider's Name, Address, & Phone #: ______________________________________

Diagnosis by Medical Provider: _____________________________________________

Does Employee Require Follow Up Treatment/consultation? (explain) ____________________

Place of incident: (i.e.; shop, office, yard, etc.) _________________________________

Address of Incident: (if other than employer's premises) ___________________________

List all Witnesses: _______________________________________________________

## Section 2 - To be completed by employer

Date Employee Last Worked Due to Incident: ___________ Date Expected to Return: ___________

Do you expect Employee to be off work more than 7 calendar days? Yes ( ) NO ( )
Did Employee provide a written release from work slip from the medical provider? Yes ( ) NO ( )
Can Employee return to his/her regular job after medical treatment (Doctor's advice)? Yes ( ) NO ( )
Can Employee return to modified work after medical treatment (Doctor's advice)? Yes ( ) NO ( )
Can modified duty work be provided within the employees physical capabilities in order to avoid time off from work? (Answer after consulting doctor at time of examination) Yes ( ) NO ( )
If yes, describe modified job duties: ___________________________________________
Did Employee refuse to work at regular job or the modified job? Yes ( ) NO ( )
(If yes contact CareWorksComp immediately)

______________________________ ______________________________
Employees Signature Date Supervisor/Foreman/Safety Dir. Date

Section 3 – To be completed by Employer – Safety/Follow Up

Was Employee performing regularly assigned duties when incident occurred? Yes ( ) NO ( )
If no, explain: ______________________________________________

______________________________________________

Was employee following company safety policies/procedures at time of incident? Yes ( ) NO ( )
If no, explain: ______________________________________________

______________________________________________

Was any equipment altered or damaged in any way that resulted in incident? Yes ( ) NO ( )
If yes, explain: ______________________________________________

______________________________________________

Was any equipment altered or damaged in any way as a result of incident? Yes ( ) NO ( )
If yes, explain: ______________________________________________

______________________________________________

Are repairs or removal of equipment from service necessary? Yes ( ) NO ( )
If yes, explain: ______________________________________________

______________________________________________

Was there a third party involvement/liability? Yes ( ) NO ( )
If yes, explain: ______________________________________________

______________________________________________

Provide all 3rd party info. (i.e. name, address, phone #, insurance company, etc.) ____________

______________________________________________

Is a reprimand of employee or other parties in order? Yes ( ) NO ( )
If yes, explain and list all parties: ______________________________________________

______________________________________________

______________________________________________

______________________________________________

Recommendations: ______________________________________________

______________________________________________

______________________________________________

______________________________________________

Action Taken: ______________________________________________

______________________________________________

______________________________________________

______________________________________________

Action Taken By: ______________________________ Date Action Taken: ____________
Name Title

______________________________ ______________________________
Supervisor/Foreman/Safety Director Date

CC- Supervisor/Foreman Personnel File Safety Director

All Parties should initial to indicate receipt & review of report. Safety personnel should ensure this has occurred as final handler of this document.

**Witness Statement**

Date of Statement ____________________

Date of Incident ____________________

Parties involved in incident (*Should note all injured parties, witnesses, etc.)*:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Statement by: ______________________________ ______________________________
Name Title

Statement: ______________________________________________________________

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______________________________ ______________________________
Signature of Witness Date statement given

______________________________ ______________________________
Notary Signature Date