Employee Accident Report

Supervisor and injured employee to complete within 24 hours of accident/injury.

Department: ______ Employee Start Time: ______

Last Name: ______ First Name: ______ Middle Name: ______

Address: ______ City: ______ State: ______ Zip: ______

Phone #: ______ Email: ______

Date of Accident/injury: ______ Time: ______

Location of Accident/injury: ______

Address: ______ City: ______ State: ______ Zip: ______

Lost Time: ☐ Yes ☐ No Date Left: ______ Time Left: ______ Date & Time Returned: ______

Supervisor: ______ Phone #: ______ Date Notified: ______

Incident investigation conducted: ☐ Yes ☐ No ☐ Safety Violation ☐ Machine Malfunction ☐ Vehicle Related

Witness Name: ______ Witness Phone #: ______

Employee Explanation of Accident/Injury: ______

(continued): ______

(continued): ______

(continued): ______

Photos need to be taken and sent in with this report form

Photos of where the injury happened (stairs, parking lot, equipment, etc.) ☐ Yes ☐ No

☐ No apparent Injury
☐ Slip/Fall
☐ Struck by Equip
☐ Lifting/Moving
☐ Caught (in, on, between)
☐ Object in Eye
☐ Laceration, Scrape, Puncture, Cut
☐ Repetitive/Overuse
☐ Other:

☐ Bruise
☐ Sprain/Strain
☐ Concussion
☐ Bite
☐ Burn
☐ Poisoning
☐ Respitory
☐ Fracture
☐ Skin Disorder, Rash

Circle Injured Areas Below

Front Back

Object Causing Injury: ______

Treatment:

☐ Clinic ☐ Hospital/ER/Urgent Care ☐ Refused Medical Care

SFM Case/Claim/Reference #: ______

Dr./Clinic Name: ______ Phone #: ______

Employee Signature: ______ Supervisor Signature: ______