Clear Form

EMPLOYEE ACCIDENT / INJURY REPORT

EMPLOYER INFORMATION

Employer/Company _____ Location _____

EMPLOYEE INFORMATION

Employee Name _____ Phone Number _____

Job Title _____ Email Address _____

Home Address _____ Apt/Unit _____

City _____ State _____ Zip _____

ACCIDENT INFORMATION

Date of Accident/Injury _____ Time of Accident/Injury _____

Date Reported to Employer _____ Time Reported to Employer _____

Complete the following information if you received medical services. Write "N/A" if none were received.

Name of Medical Provider _____ Phone Number _____

Address of Medical Provider _____

City _____ State _____ Zip _____

Employee's description of how the accident, injury, or illness occurred: *(be specific and include information on your actions and locations before, during, and following the incident)* *(Continue on page 2 if more space is needed)*

Description of Injury or Disease *(be specific and include body part, noting right or left side and the injury sustained)*

Were there any witnesses? ☐ Yes ☐ No

If Yes, Name of Witness _____ Phone Number of Witness _____

Please have the witness fill out and sign the "Witness Accident/Injury Report Form

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, or who files a statement of claim containing any false or misleading information, can be guilty of committing a felony.

By typing my name below, I acknowledge this as my signature, affirming the accuracy of the provided information and agreeing to be bound by the terms of this document.

Employee Signature _____

SUBMIT FORM

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