Employee Accident/Incident Report

Employer Information	
Company	Location
Employee Information	
Employee Name	Job Title & Department Date of Hire
Address	City, State, Zip
SSN	DOB
Accident Information	
Date and Time of Accident or Injury	Date and Time Reported to Employer
Employee's Description of How Accident or Injury Occurred	
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 & Telephone (please attach separate signed statement)
Home Address of Witness	City, State, Zip
Name and Address of Medical Provider	Telephone
Employee Signature	Date
Employer Signature	Date