

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

