EMPLOYEE INCIDENT / ACCIDENT REPORT

EMPLOYEE INFORMATION

NAME	EMPLOYEE ID	SOCIAL SECURITY NO.

JOB TITLE	DEPARTMENT

HOME ADDRESS	HOME PHONE

EMAIL ADDRESS	MALE OR FEMALE	DATE OF BIRTH

INCIDENT DESCRIPTION

LOCATION	DATE OF INCIDENT	TIME OF INCIDENT

INCIDENT DESCRIPTION
In as much detail as possible, describe what caused the incident / accident / injury, what you were doing just before the incident, and what you did after the incident. Name any objects or substances involved.

Were you performing regular duties at the time of incident?		YES		NO

Did anyone see you get hurt?		YES		NO

If YES, list all witnesses:

Did you report this incident to anyone?		YES		NO

If YES:

REPORTED TO NAME	TITLE	DATE REPORTED

If NO, explain why you chose not to report:

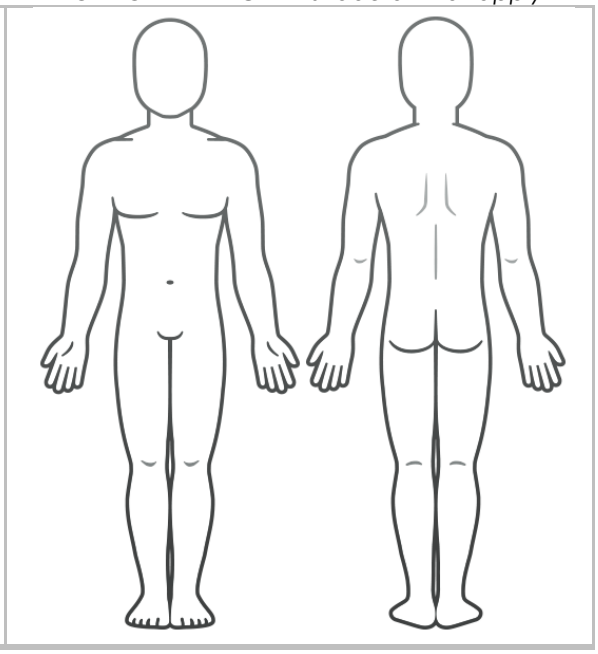
INJURY DESCRIPTION

NATURE OF INJURY *select all that apply*

	Abrasion, scrapes		Amputation		Broken Bone		Bruise		Burn (heat)
	Burn (chemical)		Concussion		Crushing Injury		Cut, laceration, puncture		
	Hernia		Illness		Sprain, strain		Damage to body system		
	Other, describe:								

DESCRIPTION OF INJURY

PART OF BODY AFFECTED *shade all that apply*



Was first aid provided at the scene?				If YES, who administered first aid?
	YES		NO	
Please describe the first aid administered.				

Was medical treatment necessary?				IF YES, NAME OF HOSPITAL / PHYSICIAN:
	YES		NO	
DATE OF VISIT		TIME OF VISIT		HOSPITAL / PHYSICIAN PHONE

Have you ever had a similar injury?		YES		NO	Has a similar injury been treated?		YES		NO
If YES, describe previous injury					If YES, where, when, and by whom were you treated?				

BACK INJURY REPORT

To be completed when a back injury is reported by the injured employee. *If not applicable, skip to next page*.

What part of your back hurts now?

When did you first notice this back pain?	DATE:		TIME:	

What were you doing at that time? Explain in detail.	
If you were lifting an object, what was it and how heavy?	
What did you feel?	
What was the length of time between the injury and your disability, if any?	

Did anyone see you get hurt?		YES		NO

If YES, list all witnesses:

Did you report this incident to anyone?		YES		NO

If YES:

REPORTED TO NAME	TITLE	DATE REPORTED

Did you ever have a back injury before?		YES		NO	Were you ever treated by a doctor?		YES		NO
If YES, when? And what part of your back?					If YES, where, when, and by whom were you treated?				

If previously injured, has it given you trouble since? Explain.

PREVIOUS COMPENSATION CLAIMS

Have you ever received or filed for compensation because of a back injury?		YES		NO

Have you ever received or filed for compensation due to any other injury?		YES		NO

If YES, list Bureau of Workers' Compensation claim numbers:

MEDICAL RELEASE

Under current Workers' Compensation Law, the employer is entitled to a signed medical release. I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury / illness described above, to disclose such information to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

EMPLOYEE NAME print	EMPLOYEE SIGNATURE	DATE

REPORT SUBMITTED BY

NAME	SIGNATURE	DATE

REPORT RECEIVED BY

NAME	SIGNATURE	DATE

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