INTERNAL ACCIDENT/INCIDENT REPORT

DATE OF THIS REPORT: _____

LOCATION WHERE INJURY OCCURRED: _____

DATE AND TIME OF ACCIDENT/INCIDENT: _____ TIME: _____ AM / PM

EMPLOYEES NAME: _____

EMPLOYEES HOME PHONE/CELL: _____

JOB BEING PERFORMED AT TIME OF INJURY: _____

TYPE OF INCIDENT:

☐ FALL ☐ SLIP ☐ HIT WITH OBJECT ☐ ELECTRICAL SHOCK ☐ LIFTING
☐ REPETITIVE MOTION ☐ REACHING/PUSHING/PULLING ☐ CHEMICAL CONTACT
☐ FLYING DEBRIS ☐ CAUGHT/PINCHED BETWEEN/UNDER ☐ LOUD NOISE
☐ TEMPERATURE EXTREMES ☐ ASCEND/DESCENT LADDER/STEPS ☐ OTHER

EXPLAIN IF OTHER MARKED: _____

_____

NATURE OF INJURY. GIVE DETAILS REGARDING TYPE OF INJURY. BE SPECIFIC:

_____

_____

PART OF BODY INJURED (INDICATE ALL INVOLVED): _____

_____

TOOLS OR OBJECT CAUSING INJURY: _____

EQUIPMENT INVOLVED: _____

DID INJURY REQUIRE MEDICAL ATTENTION: ☐ YES ☐ NO

NAME OF MEDICAL PROVIDER AND ADDRESS: _____

_____

EMPLOYEE'S DESCRIPTION OF INCIDENT: _____

_____

NAMES OF WITNESSES TO INCIDENT: _____

_____

INJURED EMPLOYEE'S SIGNATURE: _____ DATE _____

SUPERVISOR'S SIGNATURE: _____ DATE _____

NOTICE - IT IS A FELONY TO FILE A FRAUDULENT WORKERS' COMPENSATION CLAIM *****