Accident Report Form

*Important: All fields must be filled out with complete information for proper reporting to our insurance company. Original form must be sent to HR immediately.*

Employee Name

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|  |

First Name, Last Name

Title Supervisor Name

|  |  |  |
| --- | --- | --- |
|  |  |  |

Social Security Number Date of Birth

|  |  |  |
| --- | --- | --- |
|  |  |  |

XXX-XX-XXX MM/DD/YYYY

Home Address

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|  |

Cell Phone Number Email Address

|  |  |  |
| --- | --- | --- |
|  |  |  |

(XXX) XXX-XXX

Accident Type: [ ]  Slip [ ]  Trip [ ]  Fall [ ]  Other

Describe what happened in detail, including times and location of accident

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Describe what medical attention was given at the time of the accident

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Was the injured transported to the hospital? [ ]  Yes [ ]  No

If yes, Hospital Name

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| --- |
|  |

Were they transported by ambulance? [ ]  Yes [ ]  No

If no, how were they transported?

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| --- |
|  |

Did the injured return to work after the accident? [ ]  Yes [ ]  No

If yes, explain:

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|  |

Based on conditions observed, note any physical conditions during time of accident.

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Reported by Date

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| --- | --- | --- |
|  |  |  |

Title Email Address

|  |  |  |
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