ACCIDENT REPORT

EMPLOYEE INFORMATION			
Employee Name:		Employee ID:	
Social Security No:		Date of birth:	/ /
Mailing Address:		Phone Number:	

ACCIDENT INFORMATION			
Date of Injury:		Time:	am ☐ pm ☐
Location:		Phone:	( )

Provide a detailed description of the accident and the injury sustained.

Any witnesses to the accident?

Yes ☐ Names: ____

No ☐

HUMAN RESOURCES ONLY			
Date of Hire:	/ /	Position:	

HR Representative:	
Date reported to carrier:	
Report or Claim number:	

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Employee Signature Date