ACCIDENT - EMPLOYEE'S FIRST REPORT#

Immediate supervisor must complete this form promptly with employee's input.

Employee______________________________ **Position** ____________________

Date of Accident ____________________ Time ____________________ ☐ AM ☐ PM

Accident Location ____

Describe accident fully *(what happened and why; identify unsafe conditions and/or actions)*

What corrective action was taken, or is planned, to prevent similar accidents from occurring in the future?

List Witnesses & Phone Numbers

When was the accident reported?____________________ **To whom?** ____________________

Reported within 24 hours of the accident? ☐ Yes ☐ No

If not, why not?

Was the accident caused by faulty equipment? ☐ Yes ☐ No

If yes, preserve evidence and Identify

Was the accident caused by another person not employed by your firm? ☐ Yes ☐ No

Name Address

Describe injury *(part of body/type of injury)*

Describe first aid / medical treatment *(when and by whom)*

Is a previous injury or condition of the employee (or coworker) a contributing factor? ☐ Yes ☐ No

If so, explain

Is there a reason to question whether this is a job-related injury or illness? ☐ Yes ☐ No

Employee's Signature **Date**

Supervisor's Signature **Title** **Date**