



ACCIDENT INFORMATION REPORT

Return to Lucille Genovese, Benefits Administration +0602

A. THIS SECTION TO BE COMPLETED & SIGNED BY EMPLOYEE				
LAST NAME – FIRST NAME – MIDDLE NAME	Employee ID#	DATE OF BIRTH	SEX	DATE & TIME OF INCIDENT
HOME ADDRESS	PHONE NUMBER	DEPT NAME		REPORTED TO DEPT SUPERVISOR DATE TIME
JOB TITLE	LOST TIME ___ YES ___ NO	RETURN DATE		LOCATION OF ACCIDENT (Be Specific)
EMPLOYEE'S STATEMENT - INDICATE HOW, WHEN, WHERE INJURY OCCURRED & DESCRIBE PART OF BODY INJURED				
NATURE OF INJURY ___ FRACTURE ___ LACERATION ___ STRAIN/SPRAIN ___ BURN ___ FOREIGN BODY ___ OTHER		WAS FIRST AID GIVEN? ___ YES ___ NO DID YOU GO TO DOCTOR? ___ YES ___ NO, IF YES GIVE NAME _____ DID YOU GO TO HOSPITAL? ___ YES ___ NO, IF YES GIVE NAME _____		
NAME OF WITNESSES: _____ _____ _____		HAVE UP FILED FOR WORKER'S COMPENSATION BEFORE? ___ YES ___ NO, IF YES, WHERE _____ _____ _____		
I, the injured employee, herein certify that the information set forth above is true and correct to the best of my knowledge.				
Employee's Signature _____			Date Signed _____	
B. THIS SECTION TO BE COMPLETED & SIGNED BY SUPERVISOR				
DESCRIPTION AND APPARENT CAUSE OF ACCIDENT _____ _____				
IF PROPERTY/EQUIPMENT INVOLVED, DESCRIBE DAMAGE _____				
WHAT WAS INJURED DOING WHEN INCIDENT OCCURRED? _____				
CORRECTIVE ACTION RECOMMENDED _____ _____				
WAS ACCIDENT DUE TO UNSAFE EQUIPMENT OR CONDITION? _____ _____				
Supervisor's Signature _____			Date Signed _____	
C. THIS SECTION TO BE COMPLETED BY INVESTIGATOR				
HAS INVESTIGATION BEEN MADE ___ YES ___ NO, IF YES, ON WHAT DATE? _____ INVESTIGATOR'S REMARKS & RECOMMENDATIONS _____ _____				
RECOMMENDATION FOR FILING CLAIM _____ APPROVED _____ DISAPPROVED				
Investigator's Signature _____			Date Signed _____	