

# EMPLOYEE ACCIDENT REPORT

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Marital Status: S M  
(Last, First, Middle) (circle)  
Address: \_\_\_\_\_  
(street) (City) (State) (Zip)  
Phone#: \_\_\_\_\_ SS#: \_\_\_\_\_ Occupation: \_\_\_\_\_

## ACCIDENT

Date of accident: \_\_\_\_\_ Time: \_\_\_\_\_ am pm Place: \_\_\_\_\_  
What were you doing before the accident occurred? \_\_\_\_\_  
What happened? \_\_\_\_\_  
Who were you working with or who witnessed your accident? \_\_\_\_\_  
Who did you report the accident to? \_\_\_\_\_ When? \_\_\_\_\_  
What body part sustained injury? (i.e., ankle, wrist & back) \_\_\_\_\_  
Has this ever been injured before? yes no explain: \_\_\_\_\_  
What kind of injury did you have? (i.e., sprain, cut fracture) \_\_\_\_\_  
Did you miss any work? yes no did you have medical treatment? yes no  
If not, do you plan to seek medical treatment? yes no  
Physician name or clinic: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ Date seen: \_\_\_\_\_  
What treatment was order or given? (i.e., therapy, medication) \_\_\_\_\_  
Were you taken off work? yes no Were you given an off work slip? yes no  
List any future appointments scheduled: \_\_\_\_\_

## AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my employer or its authorized representative to obtain any and all records or information regarding my medical history, physical examination and treatment rendered to me related to the above reported injury.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Report this accident immediately!**

Call 815.966.3908 or 815.966.3221, and Fax this report to 815.966.3148