



2021

## EMPLOYEE ACCIDENT FORM

To be completed and signed by the employee only.

Name:	Male:	Female:	Date of birth:
Address:			
Job title:			
Phone:		Vehicle tag # (if applicable):	
Date of accident:	Time of accident:	Others injured:	
Location of accident:			
Describe how accident occurred (include events immediately before accident):			
Describe bodily injury sustained (include detailed description of body part(s) affected):			
Recommendation of how to prevent this accident from reoccurring:			
Additional equipment that could prevent the accident:			
Were pictures taken? (Yes / No):			
Name(s) of witness(es):			Phone:
Name of supervisor:			Phone:
Date accident was reported to manager:		Name of person accident was reported to:	
Did you require medical attention? (Yes / No / Maybe):			
If yes, treating physician's name:			Phone:
Treating physician's address:			

Employee's Signature: \_\_\_\_\_

Date: \_\_\_\_\_