# Accident/Illness Report

***In order for all claims to be filed correctly, this form must be filled out completely and correctly. Please print.***

## Company Information

*Prepared by* ______________________ *Job Title* ______________________ *Date of Report* ___/___/___

*Company Name* ______________________________________________ *Case or File #* ____________

*Mailing Address* ____________________________________________________________
STREET CITY STATE ZIP

*Location* ____________________________________________________________
(IF DIFFERENT FROM MAILING ADDRESS) STREET CITY STATE ZIP

## Employee Information

*Name* ______________________________________________ *Position* ____________
LAST FIRST MIDDLE

*Home Address* ____________________________________________________________
STREET CITY STATE ZIP

*Phone* ______________________ *Sex* ◯ *Male* ◯ *Female* *Date of Birth* ___/___/___

*Department* ______________________ *Employee/Payroll #* ______________________ *Shift* ____________

*Social Security #* ______________________ *Employee Insurance #* ______________________
(IN CANADA, USE SOCIAL INSURANCE NUMBER)

## Facts of Accident/Illness

◯ *Illness* ◯ *Injury* *Did Fatality Occur* ◯ *Yes* ◯ *No* *Date* ___/___/___

*Did incident occur on employer's premises?* ◯ *Yes* ◯ *No*

*If yes, address of plant/establishment* ____________________________________________

____________________________________________
CITY STATE ZIP

*Where on premises did incident occur?* ____________________________________________
(IF INJURY OCCURRED WHERE NUMBER AND STREET ARE UNIDENTIFIABLE, PROVIDE PLACE REFERENCES)

*Date of Accident/Illness* ___/___/___ *Date Reported* ___/___/___ *Time of Accident* _____:_____ *A.M.* *P.M.*

*What was employee doing when accident occurred? (Be specific)*

____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________

*How did accident occur?*

____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________

*What unsafe acts or conditions contributed to the accident?*

____________________________________________
____________________________________________
____________________________________________
____________________________________________

SAMPLE

## Facts of Accident/Illness

Describe injury/illness and describe the part of the body affected. ______________________

______________________

______________________

Name object or substance which directly injured employee. ______________________

Date of initial injury/diagnosis ___/___/___

Has any prior, related injury to affected area of body occurred at this company? ◯ Yes ◯ No

At previous companies? ◯ Yes ◯ No In an environment other than work? ◯ Yes ◯ No

## Other Information

Days away from work ______________ Days of restricted work activity ______________

**Witnesses**

1. Name ______________________ Phone ______________

   Address ______________________
   STREET CITY STATE ZIP

2. Name ______________________ Phone ______________

   Address ______________________
   STREET CITY STATE ZIP

## Medical

◯ First aid given by ______________________ Date ___/___/___ Time ___:___ A.M. P.M.

Address ______________________ Phone ______________
STREET CITY STATE ZIP

◯ Doctor's Name ______________________ Date ___/___/___ Time ___:___ A.M. P.M.

Address ______________________ Phone ______________
STREET CITY STATE ZIP

◯ Hospital Name ______________________ Date ___/___/___ Time ___:___ A.M. P.M.

Address ______________________ Phone ______________
STREET CITY STATE ZIP

◯ Released ◯ Admitted Length of stay ______________________

## Notification

Family notified by ______________________

Has Personnel Department been contacted? ◯ Yes ◯ No Date ___/___/___

Has Worker's Compensation been contacted? ◯ Yes ◯ No Date ___/___/___

Describe action taken, including preventive measures to ensure the accident does not occur again.

______________________

______________________

______________________

______________________

______________________

Approved by ______________________ Date ___/___/___

Supervisor on duty ______________________ Date ___/___/___

SAMPLE

HUMAN RESOURCE ESSENTIALS
Accident/Illness Report #5873 (stock), #5873I (imprinted)
This form does not constitute legal advice to the employer. To determine whether an employee would violate Federal, State or Local law, you should seek professional advice.
Seller assumes no responsibility for the employer's use of this form and decisions based on the information provided on this form.