Workers' Comp
Accident Report

EMPLOYEE INFORMATION

Category: Employee ☐ Student ☐ Visitor ☐ Volunteer ☐ Other:_____

Name:_____ _____ _____ Mobile phone:_____

first middle last

Address:_____ Email Address: _____

City/State/Zip Code: _____

Employee ID#:_____Pay: _____ Circle: Full Time / Part Time

Date of Hire:_____ Date of Birth:_____ SSN:_____

ACCIDENT INFORMATION

Date:_____Time of accident:_____ 911 Called: Yes ☐ No ☐ Police/TMC Security Report: Yes ☐ No ☐

Photos Taken: Yes ☐ No ☐ Taken by: (name/phone #)_____

Time employee began work day of accident: _____

Location of Accident: _____

_____

Description of Accident: _____

_____

_____

Description of any injury: _____

_____

Description of any Property Damage: _____

_____

Last day worked: _____

MEDICAL INFORMATION

Taken to Emergency Clinic: Yes☐ No☐ Taken to Hospital: Yes☐ No☐ Treatment Refused: Yes ☐ No ☐

Taken by EMS: Yes☐ No☐ Taken by Individual: (name/phone #)_____

Went to personal physician: Name: _____

Address:_____

WITNESS INFORMATION

Name: _____ Daytime Phone: _____

Name: _____ Daytime Phone: _____

Name: _____ Daytime Phone:_____

Completed by: _____ **Date:** _____

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