EMPLOYEE INCIDENT/ACCIDENT REPORT

To Be Completed by Injured Employee *OSHA 301 Info in BOLD

Print Form

Name | Social Sec. No.

Home Address | Date of Birth | Sex: ☐ Male ☐ Female

City/State/Zip. | Phone Number

Title/Position | Department

Accident Location

Date and Time of Injury or Onset of Symptons

Describe what caused the injury/symptoms, what you were doing just before the incident, and what you did after the inciden. (If you need more spac, write on the back of this form). Be specific-name any objects or substances involved.

Were you performing regular duties at the time of accident? ☐ Yes ☐ No

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who?

Did you report this incident to anyone? ☐ Yes ☐ No If no, why not?

If yes, to whom did you report it? Title/Position? When:

What time did you start work today? ☐ am ☐ pm What time was the injury? ☐ am ☐ pm

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What part(s) of your body was/were affected? (**BE SPECIFIC**: for example, right elbow, left knee, right index finger):

What type of injury did you experience? **(BE SPECIFIC**: for example, bruise, scrape, laceration, pull):

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe: First Aid provided by:

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?: Where?

If treatment was not sought immediately, explain why?:

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury? By whom/where :

Have you ever had a similar injury? ☐ Yes ☐ No If yes, descibe other injury:

Medical Release: Under current Workers' Compensation Law, the employer is entitled to a signed medical release. I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have informtion of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to my employer, my emploer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name :

Employee Signature / Date