

## ACCIDENT REPORT

**Part 1: To be completed by injured worker and supervisor**

Name: \_\_\_\_\_ Male:  Female:   
 Home Address: \_\_\_\_\_ Married:  Single:   
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
 Department in which regularly employed: \_\_\_\_\_  
 Job Classification: \_\_\_\_\_ Hire Date: \_\_\_\_\_ Hours work per day: \_\_\_\_\_ # of days/week: \_\_\_\_  
 Was another person responsible?  Yes  No Name of witness(es): \_\_\_\_\_  
 On date of injury time started work: \_\_\_\_\_ Time work ended: \_\_\_\_\_

**Part 2: Injury / Illness Information**

Date of Injury / Illness: \_\_\_\_\_ Time Injury / Illness Occurred: \_\_\_\_ AM \_\_\_\_ PM  
 Where did injury occur? (Specific Location): \_\_\_\_\_  
 What was the employee doing when injury/illness occurred? (Be specific. Tell what and how it happened): \_\_\_\_\_  
 \_\_\_\_\_  
 Object or substance that directly injured the employee: \_\_\_\_\_  
 Part of body affected. (Be Specific: Right hand-Left hand?): \_\_\_\_\_  
 Did injury / illness require medical attention?  Yes  No  
 Name/ address of treating physician: \_\_\_\_\_  
 I have verified the employee was at work at date and time of incident as stated above.  Yes  No  
 Do facts indicate the injury happened at work?  Yes  No  
 Did injury/illness cause absence from work  Yes  No  
 Has employee returned to work?  Yes  No  
 Date returned to work: \_\_\_\_\_

**Part 3: Safety Information**

An unsafe condition existed (check all that apply):      An unsafe act resulted from (check all that apply):  
 defective equipment                                       lack of training                       not following safety rules  
 equipment not properly guarded                       chance taking                       inattention  
 poor working conditions (lights)                       horseplay                       improper work method  
 slippery/uneven walking surface                       other: \_\_\_\_\_  
 poor housekeeping

**Part 4: Signatures**

\_\_\_\_\_  
 Employee Signature                                      Date                                      Supervisor/Manager Signature                                      Date

DOI _____	Report Date _____
UEI# _____	Report # _____
<input type="checkbox"/> Recordable <input type="checkbox"/> Un-recordable	<input type="checkbox"/> Report Only _____
<input type="checkbox"/> Medical <input type="checkbox"/> No Medical	<input type="checkbox"/> 1st Aid _____
DWC-1 Returned _____	Date Returned _____
DWC-1 Sent to _____	Date Sent to IW _____

Risk Management Use Only:

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