

- EMPLOYEE
- VISITOR
- OTHER _____

ACCIDENT REPORT

NAME			DATE		
HOME ADDRESS		CITY		STATE	ZIP
HOME PHONE		SOCIAL SECURITY NUMBER		AGE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
EMPLOYEE/CLOCK NO.	POSITION		DEPARTMENT	SHIFT	

DESCRIPTION OF ACCIDENT

LOCATION OF ACCIDENT _____

TIME OF ACCIDENT	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF ACCIDENT	TIME REPORTED	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE REPORTED
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Describe what took place _____

INSIDE

OUTSIDE

- Lighting: Poor Good Excellent
- Floor type: Cement Tile Carpet
 Wood Other
- Conditions of floor: Dry Wet
 Fresh wax New carpet

- Weather: Clear Rain Fog
 Snow Ice Sleet
 Bright Cloudy Dusk
 Surface conditions

Other conditions: _____

Describe any tools, chemicals, or machinery involved in Accident: _____

Describe injury, if any: _____

MEDICAL ATTENTION GIVEN

- First aid given, by whom _____ ambulance called taken to hospital doctor/clinic called
- _____ ADMITTED RELEASED

HOSPITAL/DOCTOR'S NAME _____

HOSPITAL/DOCTOR'S ADDRESS _____

If no medical attention was given, please explain: _____

WITNESSES

NAME	ADDRESS	PHONE
NAME	ADDRESS	PHONE