

Employee Accident Form

The completion of this form is the 1st step in an internal multi-step accident investigation. Please complete this form timely, accurately, and fully. Failure to honestly complete and submit this form within 24 hours of the accident may limit benefit options.

Employee Name:	
Employee Position/Title:	
Building Location (Circle):	CEC WLC WHS WMS Other: _____
Specific Location of Incident (e.g., Room 205, Gym Floor, Parking Lot):	

Time Employee Started Work (On date of accident):	:		AM	PM
Date of Accident/Injury:				
Time of Accident/Injury (e.g., 2:30 PM):	:		AM	PM
Date Form Completed:				
Time Form Completed:	:		AM	PM

Affected Body Part (Check all that apply):	Left	Right	Description/Notes
Head/Face/Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	<input type="checkbox"/>	
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	
Arm (Upper)	<input type="checkbox"/>	<input type="checkbox"/>	
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	
Wrist/Hand/Fingers	<input type="checkbox"/>	<input type="checkbox"/>	
Back (Upper)	<input type="checkbox"/>	<input type="checkbox"/>	
Back (Lower)	<input type="checkbox"/>	<input type="checkbox"/>	
Chest/Ribs	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Leg (Upper/Thigh)	<input type="checkbox"/>	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	<input type="checkbox"/>	
Ankle/Foot/Toes	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	

What was the Nature of the Injury? (Check all that apply)	Details
<input type="checkbox"/> Fracture/Broken Bone	
<input type="checkbox"/> Sprain/Strain/Tear	
<input type="checkbox"/> Cut/Laceration/Puncture	
<input type="checkbox"/> Bruise/Contusion	
<input type="checkbox"/> Burn (Chemical/Heat)	
<input type="checkbox"/> Concussion/Head Trauma	

<input type="checkbox"/>	Rash/ Allergic Reaction	
<input type="checkbox"/>	Foreign Body (Eye/Skin)	
<input type="checkbox"/>	Other (Specify):	

Have you or will you receive medical treatment?		
<input type="checkbox"/>	No	
<input type="checkbox"/>	Yes (If yes, complete below)	
Where was the treatment sought?		Name of Medical Provider:
<input type="checkbox"/>	Emergency room	
<input type="checkbox"/>	Urgent care	Did the Employee Return to work after treatment?
<input type="checkbox"/>	Doctors Office	<input type="checkbox"/> Yes
<input type="checkbox"/>	On-site Nurse/First Aid	<input type="checkbox"/> No (If no, Indicate expected date of return/leave status):

Accident Narrative

Provide as much detail as possible to ensure accurate reporting.

1. Describe the surrounding environment right before the accident.

2. Describe exactly what the employee was doing at the moment of the accident.

3. Describe exactly how the injury occurred.

4. What object, substance, or equipment was involved in the accident.

5. What safety equipment was being used?

6. Did any environmental, Material, or structural factors contribute to the incident? If so, please describe them.

