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	☐	☐	
Neck	☐	☐	
Shoulder	☐	☐	
Arm (Upper)	☐	☐	
Elbow	☐	☐	
Wrist/Hand/Fingers	☐	☐	
Back (Upper)	☐	☐	
Back (Lower)	☐	☐	
Chest/Ribs	☐	☐	
Abdomen	☐	☐	
Leg (Upper/Thigh)	☐	☐	
Knee	☐	☐	
Ankle/Foot/Toes	☐	☐	
Other:	☐	☐	

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

☐	Rash/ Allergic Reaction	
☐	Foreign Body (Eye/Skin)	
☐	Other (Specify):	

Have you or will you receive medical treatment?			
☐	No		
☐	Yes (If yes, complete below)		
Where was the treatment sought?		Name of Medical Provider:	
☐	Emergency room		
☐	Urgent care	Did the Employee Return to work after treatment?	
☐	Doctors Office	☐	Yes
☐	On-site Nurse/First Aid	☐	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 invloved 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.

7. Was the incident reported immediatly to a supervisor? If not, when was it reported and to whom?
8. Were there any witnesses to the incident? If so, please list their names and positions below.
9. Was the employee performing thier regular, assigned job duties at the time of the incident? If not, what were they doing and why?
10. In the employee's opinion, what could have been done to prevent this incident from occuring?

☐	By checking this box and signing this form, I agree that this form is completed accurately to the best of my knowledge.

Employee Signature: Date:

Supervisor Signature: Date: