EmployeeAccident Report

Any work related injury and/or illness must be reported to a supervisor immediately, per company policy. This form shall be completed by the injured worker and reviewed with the supervisor, and saved for company records.

Employee Name: _____ **Position:** _____

Date of Injury: _____ **Time:** _____

Supervisor name: _____ **Location:** _____

☐Provided Designate Provider Notification

Briefly Describe the Injury and/or Illness AND How it Occurred: _____

_____

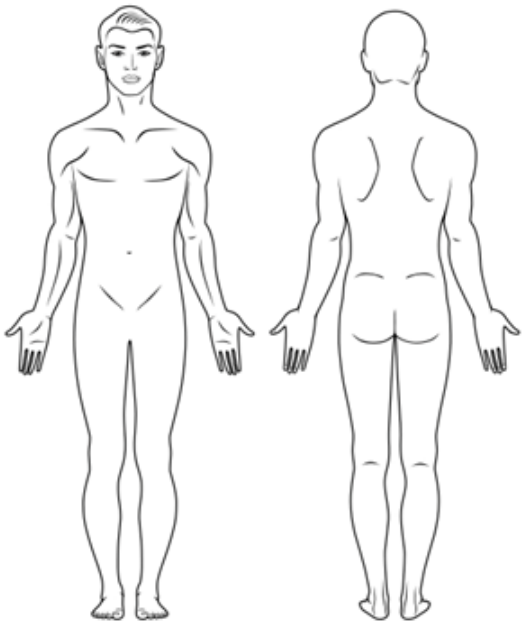
_____

_____

Supervisor notes: _____

_____

Body Part Injured:



Recommendations to Avoid Future Incident: _____

_____

_____

By signing below, I confirm that all of the information provided here and on any attachments is complete and true to the best of my knowledge, and that my supervisor has reviewed the information contained within.

_____ _____

Employee **Date**

_____ _____

Supervisor **Date**