



Accident Report

This accident report needs to be completed by the employee within 24 hours of an occurrence or as soon as possible thereafter. Please send the completed form to The Employer Group along with the First Report of Injury after completion by the onsite supervisor.

Name: _____ Social Security #: _____

Address: _____

Onsite Supervisor's name: _____ Telephone #: _____

Accident date: _____ Time: _____ a.m. /p.m.

Time shift began: _____ a.m. /p.m. Location of accident: _____

How did the accident occur? _____

What was being done before the accident occurred? _____

Details of what happened (please use a second sheet if necessary): _____

Was this a part of normal job duty? _____

Witnesses (name and phone #): _____

Body part(s) affected or injured: _____

Type of illness or injury: _____

Describe what, if any, pain you experienced: _____

Where is the pain located? _____

Describe any other symptoms you experienced:

Did the accident involve any unsafe condition or unsafe conduct? (please describe)

Did you seek medical treatment: yes/no If yes, where? _____

Employee's Signature: _____ Date: _____