

## EMPLOYEE INCIDENT/ACCIDENT REPORT

To Be Completed by Injured Employee \* OSHA 301 Info in BOLD

Name: _____	Social Sec. No. <b>XXX-XX-</b> _____ (Last 4-digits only)
Home Address: _____	Date of Birth: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City/State/Zip: _____	Telephone: (    ) _____
Title/Position: _____	Department: _____

Accident Location: \_\_\_\_\_

Date of Injury or onset of symptoms: \_\_\_\_\_ Time: \_\_\_\_\_  am  pm

**Described what caused the injury/symptoms, what you were doing just before the incident, and what you did after the incident (if you need more space, write on the back of this form). Be specific-name any objects or substances involved:**

\_\_\_\_\_

\_\_\_\_\_

Were you performing regular duties at the time of accident?  Yes  No

Did anyone see you get hurt?  Yes  No If yes, who? \_\_\_\_\_

Did you report this incident to anyone?  Yes  No If no, why not? \_\_\_\_\_

If yes, to whom did you report it?: \_\_\_\_\_ Title/Position: \_\_\_\_\_ When: \_\_\_\_\_

What time did you start work today? \_\_\_\_\_ am/pm. What time was the injury? \_\_\_\_\_ am/pm  Unknown

**What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):**

\_\_\_\_\_

\_\_\_\_\_

**What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull):** \_\_\_\_\_

\_\_\_\_\_

Was any first aid provided at the scene?  Yes  No If yes, describe: \_\_\_\_\_

Provided by: \_\_\_\_\_

Did you seek other medical treatment?  Yes  No If yes, when?: \_\_\_\_\_

Where?: \_\_\_\_\_ If treatment was not sought immediately, explain why?: \_\_\_\_\_

\_\_\_\_\_

Is this an aggravation of a previous injury/symptom?  Yes  No If yes, when were you last treated for the previous injury?: \_\_\_\_\_ By whom or where?: \_\_\_\_\_

Have you ever had a similar injury?  Yes  No If yes, describe other injury: \_\_\_\_\_

**Medical Release – Under current Workers' Compensation Law, the employer is entitled to a signed medical release.** I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print): \_\_\_\_\_ Employee Signature: \_\_\_\_\_

Date (required): \_\_\_\_\_