

Employee Accident Report Summary

I. Employee Information:			
Name:		D.O.B:	SSN:
Address:		Phone #:	
Occupation:	D/ Hire:	Salary : _____/hr _____/week	
II. Accident Information:			
Injury Date:	Time: AM PM	Date Reported:	Reported To:
If Loss Occurred Off Premise, Location of Accident:			
Description of How Accident Occurred: (provide a brief narrative and check the box below that best describes the proximate cause of loss)			
<input type="checkbox"/> Caught in / under between <input type="checkbox"/> Slip or trip (not fall) <input type="checkbox"/> Slip or fall – same level <input type="checkbox"/> Slip or fall - from elevation <input type="checkbox"/> Slip or fall – weather related	<input type="checkbox"/> Injury – burn <input type="checkbox"/> Injury – abrasion / laceration <input type="checkbox"/> Injury – foreign body <input type="checkbox"/> Material handling – manual <input type="checkbox"/> Material handling – mechanical	<input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Struck by / against <input type="checkbox"/> Chemical/ toxic fume exposure <input type="checkbox"/> Other; explained above	
Witness Name(s):			
Description of Injury:			
For injuries involving fingers, hands, wrists or arms: (Please circle the appropriate choice)			
The injury occurred to my: RIGHT LEFT BOTH extremity(s)		I am: RIGHT LEFT hand dominant	
III. Medical Treatment and Disability:			
Nature of Initial Treatment:	<input type="checkbox"/> No medical treatment required <input type="checkbox"/> Minor – By employer <input type="checkbox"/> Minor – clinic / hospital	<input type="checkbox"/> Emergency (ambulance called) <input type="checkbox"/> In-patient Hospitalization (≥ 24 hours) <input type="checkbox"/> Future Major Medical	
Name and Address of Initial Treatment Provider:			
Did employee leave work at time of Injury:		Has employee returned to work?	
If Yes, date & time of return to work:		RTW Status: <input type="checkbox"/> Modified Duty <input type="checkbox"/> Full Duty	
IV. Management / Risk Control:			
Insurance Carrier :	Policy #:	Date Claim Reported:	
Claim Accepted by employer as Work related? If no, explain:			
Claim type and severity:	<input type="checkbox"/> First time this type of claim <input type="checkbox"/> Medical only claim <input type="checkbox"/> Lost time claim	<input type="checkbox"/> Notice only / No claim filed <input type="checkbox"/> Minor – Under \$500 <input type="checkbox"/> Serious – Over \$500	
If Employee has not RTW, target RTW Date:		RTW Plan: <input type="checkbox"/> Modified Duty <input type="checkbox"/> Full Duty	
Have RTW options been discussed with employee?		Medical Provider?	
Actions taken to avoid similar future Incidents:	<input type="checkbox"/> Employee counseling / Discussion <input type="checkbox"/> Employee training / re-training <input type="checkbox"/> Equipment repair or alteration	<input type="checkbox"/> Equipment removed from use <input type="checkbox"/> Safety Committee Discussion / Issue <input type="checkbox"/> No action taken / required	
Person(s) Responsible :		Target Completion Date:	
If equipment issue, explain issue and corrective measure taken:			
Initial Report Prepared By:			Date:
Secondary Review By:			Date:

