07/02

ACCIDENT REPORT FORM

INDIVIDUAL'S NAME: ______________________________ DEPT. ______________

ON PREMISES FOR: ____

DATE & TIME INJURED: ______________ AM PM DATE & TIME REPORTED: ______________ AM PM

NATURE OF INJURY: ____

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HOSPITAL OR DOCTOR TREATMENT REQUIRED: YES or NO ______________________

INJURED INDIVIDUAL'S HAND WRITTEN DESCRIPTION OF ACCIDENT: ______________________

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ACCIDENT WITNESSES: ____

WERE GUARDS, PROTECTIVE CLOTHING, & EQUIPMENT BEING USED: YES or NO ______________

WHAT CONDITIONS OR CIRCUMSTANCES MADE THIS ACCIDENT POSSIBLE: ______________________

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WHAT ACTION HAS BEEN (OR WILL BE) TAKEN TO PREVENT SIMILAR ACCIDENTS: ______________

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PLEASE ATTACH WITNESSES HANDWRITTEN DESCRIPTION OF ACCIDENT IF DEEMED NECESSARY.

INJURED INDIVIDUAL'S SIGNATURE: ____

REPORT TAKER'S SIGNATURE & TITLE: ____

DATE: ______________________________

PLEASE RETURN COMPLETED FORM TO OFFICE OF THE TREASURER