



# EMPLOYEE ACCIDENT & INJURY REPORT

Accidents MUST be reported to Human Resources / District Managers within 24 hrs of accident.

This section is to be completed by HR ONLY.

OSHA 300 Log: YES / NO

08 - \_\_\_\_\_

Submit to Insurance Company: YES / NO  Report ONLY  Medical ONLY  Full Compensation

Ultipro Case #

Carrier Case #: \_\_\_\_\_ Case Manager: \_\_\_\_\_

CM Phone#: ( ) \_\_\_\_\_ CM Fax #: ( ) \_\_\_\_\_

Total Lost Calendar Days: \_\_\_\_\_ From: \_\_\_\_\_ to \_\_\_\_\_ From: \_\_\_\_\_ to \_\_\_\_\_

Total Restricted Days: \_\_\_\_\_ From: \_\_\_\_\_ to \_\_\_\_\_ From: \_\_\_\_\_ to \_\_\_\_\_

Injured Employee's Name: \_\_\_\_\_

Work Location: \_\_\_\_\_

Home Address : \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Job Title: \_\_\_\_\_

Home Phone :( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Length of time in position: \_\_\_\_\_

Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_

FT or PT: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_ AM or PM

Gender:  Male or  Female

Time employee began work: \_\_\_\_\_ AM or PM

Date Injury reported: \_\_\_\_\_ Time : \_\_\_\_\_ AM or PM

Employee's Regular Work Schedule - (circle days work)

Sun Mon Tues Wed Thurs Fri Sat

## WHAT WAS THE EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?

Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Example: "climbing a ladder while carrying roofing material", "daily computer key-entry".

## WHAT PPE WAS REQUIRED? (Circle all that apply)

Bump Cap/Head Protection Goggles/Eye Protection  
Proper Foot Wear Ear Plugs  
Gloves Hand/Arm Protection Other: \_\_\_\_\_

NO WAS THE PROPER PPE WORN? (Circle one) YES or

If No, why not? \_\_\_\_\_

## HOW DID INJURY OCCUR?

Explain how the injury occurred. Example: "when ladder slipped on wet floor, worker fell 20 feet", "worker developed soreness in wrist over time."

## WERE PROPER SAFETY PROCEDURES FOLLOWED?

(Circle one) YES OR NO.

If no what procedures were not followed? \_\_\_\_\_

## WHAT WAS THE INJURY OR ILLNESS?

Tell us the part of the body that was affected and how it was affected; be more specific, than "HURT," or "SORE". Examples: "strained back"; "carpal tunnel syndrome."

## IF PROPER PPE AND / OR SAFETY PROCEDURES WERE NOT FOLLOWED WAS THE EMPLOYEE COUNSELED?

Yes - Copy of counseling form attached

No - Explain why NOT \_\_\_\_\_

## WHAT OBJECT / SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?

Examples: "concrete floor"; "radial saw." If this question does not apply to the Workers Cover Page incident leave it blank.

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WHAT FIRST AID TREATMENT WAS PERFORMED ON SITE IF ANY? \_\_\_\_\_

## INFORMATION ABOUT THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL

DID THE EMPLOYEE SEEK OUTSIDE MEDICAL ATTENTION?  YES or  NO

If YES, complete the following information:

Name of physician or other health care professional: \_\_\_\_\_

If treatment was given away from the worksite, where was it given?

Facility Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Was employee treated in an emergency room?  YES or  NO

Was employee hospitalized overnight as an in patient?  YES or  NO

## AS EMPLOYEE RETURNED TO WORK?

\_\_\_\_ YES - Without Restrictions      \_\_\_\_\_ YES - With Restrictions      \_\_\_\_\_ NO - Expected return date: \_\_\_\_/\_\_\_\_/\_\_\_\_

AS EMPLOYEE PAID FOR THE REMAINDER OF THEIR SHIFT?  YES  NO (If no please explain) \_\_\_\_\_

WITNESSES NAME(S): \_\_\_\_\_

LOCATION MANAGER NAME: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

REPORT COMPLETED BY: \_\_\_\_\_

DAY'S DATE : \_\_\_\_/\_\_\_\_/\_\_\_\_

### HUMAN RESOURCES USE ONLY

#### ADDITIONAL COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_