



# ACCIDENT INFORMATION REPORT

Return to: Lucille Genovese, Benefits Administration +0602

A. THIS SECTION TO BE COMPLETED & SIGNED BY EMPLOYEE				
LAST NAME – FIRST NAME – MIDDLE NAME	Employee ID#	DATE OF BIRTH	SEX	DATE & TIME OF INCIDENT
HOME ADDRESS	PHONE NUMBER	DEPT NAME		REPORTED TO DEPT SUPERVISOR  DATE <span style="float: right;">TIME</span>
JOB TITLE	LOST TIME  YES ___ NO ___	RETURN DATE		LOCATION OF ACCIDENT (Be Specific)
EMPLOYEE' S STATEMENT - INDICATE HOW, WHEN, WHERE INJURY OCCURRED & DESCRIBE PART OF BODY INJURED				
NATURE OF INJURY  ___ FRACTURE                      ___ LACERATION  ___ STRAIN/SPRAIN                ___ BURN  ___ FOREIGN BODY                ___ OTHER		WAS FIRST AID GIVEN?    ___ YES    ___ NO DID YOU GO TO DOCTOR?   ___ YES    ___ NO, IF YES GIVE NAME _____  DID YOU GO TO HOSPITAL? ___ YES    ___ NO, IF YES GIVE NAME _____		
NAME OF WITNESSES: _____ _____ _____		HAVE UP FILED FOR WORKER'S COMPENSATION BEFORE? ___ YES    ___ NO, IF YES, WHERE _____ _____ _____ _____		
I, the injured employee, herein certify that the information set forth above is true and correct to the best of my knowledge.				
_____ Employee's Signature			_____ Date Signed	
B. THIS SECTION TO BE COMPLETED & SIGNED BY SUPERVISOR				
DESCRIPTION AND APPARENT CAUSE OF ACCIDENT _____ _____				
IF PROPERTY/EQUIPMENT INVOLVED, DESCRIBE DAMAGE _____				
WHAT WAS INJURED DOING WHEN INCIDENT OCCURRED? _____				
CORRECTIVE ACTION RECOMMENDED _____ _____				
WAS ACCIDENT DUE TO UNSAFE EQUIPMENT OR CONDITION? _____ _____				
_____ Supervisor's Signature			_____ Date Signed	
C. THIS SECTION TO BE COMPLETED BY INVESTIGATOR				
HAS INVESTIGATION BEEN MADE ___ YES    ___ NO, IF YES, ON WHAT DATE? _____ INVESTIGATOR'S REMARKS & RECOMMENDATIONS _____ _____				
RECOMMENDATION FOR FILING CLAIM                      ___ APPROVED                      ___ DISAPPROVED				
_____ Investigator's Signature			_____ Date Signed	