Employee's Report of Accident

To be completed by Injured Employee

Personal Information			
Driver's License Number :	**Social Security Number:**		
Full Legal Name:	**Claim Number:**		
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Gender:**	**M F**
Email Address:	**Date of Birth:**		
Job Position:	**Wages:** (annual salary or hourly rate)		
Building:	**Number of Hours Worked per Week:**		
Date of Hire:	**Marital Status:**	**Number of Dependents:**	

Incident Information	
Date of Injury:	**Time of Injury:** ◯ **AM** ◯ **PM**
Date Reported:	**Location:**
Accident Reported to (Name and Title)**:**	
Accident Description / Summary of Incident (Describe fully, Include body part that was injured)	
Initial Medical Treatment: ◯ **None Required** ◯ **Refused** ◯ **First Aid Only** ◯ **Physician/ Treatment Facility Visit** ◯ **Emergency Room Visit**	**Date of Initial treatment:**
Witness Name:	**Phone Number:**
Witness Name:	**Phone Number:**
Are you still under medical treatment? ◯ **Yes** ◯ **No**	**If yes, how often do you receive treatment?**
Name and contact information of doctor treating you:	
Did you stop work as a result of your accident? ◯ **Yes** ◯ **No**	**If yes, list dates:**
Was your pay continued during any part of your disability? ◯ **Yes** ◯ **No**	
If yes, for what period:	
If not working, when do you expect to return to work?	
Employee Signature:	**Date:**