

EMPLOYEE ACCIDENT REPORT

Answer all questions fully. Attach additional sheets as needed.

Name: _____ SSN: _____

Address: _____ Phone: _____

Date of accident: _____ Approximate time: _____ Shift _____

Date of Birth: _____ Date of Hire: _____ Circle: Male Female

Department / Town / Village _____

Location of Accident (Address) _____

What were you doing before you were hurt? _____

Describe in detail how accident happened: _____

What part of your body did you hurt? _____

Did you see a doctor? Yes No If yes, provide:

Physician Name: _____

Hospital Name: _____

Did you stay over _____

Were you told to go see another doctor? Yes No If yes, provide:

Physician name and address: _____

Have you previously been hurt at work? Yes No

If Yes, give date of prior injury _____

Witnesses _____

It is a crime punishable as a Class A Misdemeanor under the laws of the State of New York for a person in and by a written instrument to knowingly make a false statement or to make a statement which such person does not believe to be true. By signing below you independently and voluntarily request that your name NOT be entered on the "Log of Work-Related Injuries and Illness," in case of work-related illness or injury.

Today's date

Employee Signature

Supervisor Signature

Note to Supervisors: If you have any questions or concerns regarding how this accident occurred, or if you want to provide further information, please call Self-Insurance at 761-6529.