Employee Accident Record Form

Employee Information

Full Name:

Department/Job Title:

Employee ID:

Contact Information:

Accident Details

Date of Accident:

Time of Accident:

Location of Accident:

Description of Accident (include events leading up to it):

Describe Injuries Sustained:

Was Medical Treatment Provided? If Yes, describe:

Equipment or Substances Involved (if any):

Witness Details

Name	Contact	Statement

Additional Information

Report Date:

Reported By (Name/Position):

Actions Taken to Prevent Reoccurrence:

Supervisor/Manager Comments:

Signatures

Employee Signature:

Supervisor/Manager Signature: