EMPLOYEE ACCIDENT REPORT

DIRECTIONS: Accident Reports must be completed and submitted to the employee's immediate supervisor within 24 hours of the accident/illness except where the injury/illness prevents the employee from filing a report.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / Mi / Last) 2. Date of Birth: _____ /_____/_____

3. Mailing address: _____ (Number and Street /PO Box / City / State / Zip Code)

4. Phone Number: (_____) _____ 5. Gender: ☐ Male ☐ Female

6. Do you speak English? ☐ Yes ☐ No If no, what language do you speak? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (_____)_____

3. Your work address: _____ (Number and street / City / State / Zip Code)

4. Date you were hired: _____ /_____/_____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

_____

_____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

_____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

_____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: _____/_____/_____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

_____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

_____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

_____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor)_____

_____

_____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

_____

_____

YOUR NAME: _____ (First) (Mi) (Last) **DATE OF INJURY/ILLNESS:** _____/_____/_____

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer. acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____
   _____

10. Have you given your employer (or supervisor) notice of you injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: _____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____
    _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? _____/_____/_____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/_____/_____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OF ILLNESS

1. What was the date of your first treatment? _____/_____/_____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/ Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (_____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (_____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you:
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

For Office Use Only

Social Security Number: _____ – _____ – _____

Employee's Signature: _____ Date: _____/_____/_____

Supervisor's Signature: _____ Date: _____/_____/_____

Director's Signature: _____ Date: _____/_____/_____