



REPORT OF ACCIDENT/INCIDENT

(Attach eyewitness accounts signed by witness)

Employee's Name: _____ **Employee ID Number:** _____

Position / Title: _____

Supervisor's Name: _____

Date and Time of Accident: _____

Date and Time Reported: _____

Person to whom the accident was reported: _____

Task being performed when accident occurred:

Witnesses: (names and phone numbers)

Describe how the accident occurred:

Injuries Sustained:

What could have been done to prevent accidents of this type?

If injury occurred due to a safety hazard, what has been done to eliminate the hazard?

If the injury involved a vehicle, was the employee performing his/her job duties at the time of the accident? Yes ___ No ___ If no, please explain. (Attach police report if available)

Was the employee determined to be at fault for this auto accident? Yes ___ No ___

Was the employee wearing a seatbelt? Yes ___ No ___

Is the employee required to use any safety equipment? Yes ___ No ___

Was he/she using it at the time of the accident? Yes ___ No ___

Were there any signs of drug or alcohol use by the employee? Yes ___ No ___

Did this injury result from exposure to a contagious disease? Yes ___ No ___ If yes, please provide details.

Do you agree with the description of the accident on the First Report of Injury or Illness? Yes ___ No ___ If no, please explain.

Is the employee dually employed? Yes ___ No ___ If yes, where?

Supervisor: _____ Date: _____
(Print Name)

Employee: _____ Date: _____
(Signature)

By signing this document, the employee attests that the information contained herein is true and accurate to the best of the employee's knowledge.

cc: Bureau of Human Resources, WC Human Resources Technician III
Safety Specialist
Human Resources Liaison
Office Safety Committee Chairperson