

**EMPLOYEE ACCIDENT REPORT FORM
(USE ONLY IF EMPLOYEE DOES NOT SEEK MEDICAL ATTENTION)**

PRINT OR TYPE:

Name: _____ Dept: _____

Accident Date: _____ Time: _____ [] a.m. [] p.m.

Accident Location: _____

Describe Accident:

Describe Injury: _____

Witnesses: _____

If accident was caused by another person or persons, list names: _____

If previous injury/condition of employee was a factor, explain: _____

Describe action taken to prevent a similar occurrence: _____

Employee's signature: _____ Date: _____

Supervisor's signature: _____ Date: _____

Original: Office of Human Resources

Cc: Employee

Cc: Supervisor