

EMPLOYEE ACCIDENT REPORT

(Completed by employee)

OPERATING LOCATION: _____



NAME _____

HOME PHONE _____

JOB TITLE _____

HOME ADDRESS _____

ZIP _____

BIRTH DATE ____/____/____

HIRE DATE ____/____/____

DATE OF INJURY OR ONSET ____/____/____ TIME ____:____

DATE OF LAST SAFETY MTG ____/____/____

DETAILED DESCRIPTION OF EVENT:

WITNESS _____

SPECIFIC LOCATION: (yard, sidewalk, crawlspace, street, attic, etc.)

WHAT COULD BE DONE TO PREVENT A SIMILAR INCIDENT:

SYMPTOM DESCRIPTION

LOCATION (check right or left and circle those that apply)

LEFT RIGHT

____ ____

shoulder **neck** **arm**

wrist

hand

finger(s)

____ ____

mid back (belt to shoulder blade)

low back (belt and below)

upper back (shoulder blade to base of neck)

____ ____

leg

knee

ankle

foot

hip

SYMPTOMS (circle those that apply)

pain

numbness

tingling

stiffness

weakness

PAIN (check if applicable)

____ **dull / sore**

____ **radiates to right**

____ **radiates to left**

____ **spasms**

____ **sharp / stabbing**

____ **pulling sensation**

____ **tightness**

____ Other pain description: _____

Duration of pain _____

frequency of pain _____

Authorization to release medical records: With my signature below I authorize release of any/all medical records relating to this work injury, to the employer/ insurance carrier.

EMPLOYEE SIGNATURE _____

DATE SIGNED _____