



EMPLOYEE ACCIDENT REPORT

Please complete and return, along with the DWC1 form, to Human Resources within 24 hours or the next business day following the accident

Employee's Name: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ Zip Code: _____

Phone #: _____ Email Address: _____

Home Department: _____ Job Title: _____

Employment Status (Please check): Full-time Part-time Student

Date of Injury: _____ Time of Injury: _____ AM/PM Time Shift Began: _____ AM/PM

Department or Location of Accident: _____

Specific injury/illness and part of body affected. (e.g. Second degree burns on right arm, tendonitis on left elbow, lead poisoning, etc.)

Equipment, materials and/or chemicals the employee was using when the event or exposure occurred. (e.g. Knife, welding torch, ladder, etc.)

Specific activity the employee was performing when the event or exposure occurred. (e.g. Cutting fruit, loading boxes, cleaning the oven, etc.)

How did the injury/illness occur? Describe the sequence of events. Specify the object(s) or exposure which directly produced the injury/illness. (e.g. Worker stepped into the walk-in freezer and slipped on a piece of ice. As the worker was cleaning the oven, his right hand brushed up against the hot metal rack and burned right hand.)



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Was another person involved in the injury/illness? Yes No

If "Yes", Name: _____ Phone #: _____

Were there any witnesses to the injury/illness? Yes No

If "Yes", please attach statements written from each witness.

Witness Name: _____ Phone #: _____

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Please check one of the following:

I choose to accept medical treatment/evaluation and file a claim for the above noted condition and will go to the appropriate medical facility the Forty-Niner Shops, Inc. has designated.

I choose to decline medical treatment/evaluation and filing a claim for the above noted condition. I understand that I do have the right to change my mind, within one-year from the date of injury, to file a Workers' Compensation claim. By signing this document, I also understand that should I decide to seek medical treatment for this injury/illness, I must immediately notify by Manager, Supervisor and/or Human Resources and go to the appropriate medical facility the Forty-Niner Shops, Inc. has designated.

Employee Signature

Date

Manager/Supervisor Signature

Date

This section to be completed by Human Resources

Is video surveillance available? Yes No

If "Yes", is the video secured? Yes No

Did the employee complete their scheduled work shift? Yes No

Did the employee lose at least one full-day of work after the injury? Yes No

Has the employee returned to work? Yes No

Date of the employee's next scheduled shift: _____ Hire Date: _____ Rate of Pay: _____

Workers' Comp Code: 1001/Clerical 1004/Retail 1006/Food Service 1007/Manual Labor

Referred to Workers' Compensation Insurance Provider: Yes No

If "Yes", was the employee given Notice of Workers' Comp Benefits within 5 working days of the injury? Yes No

Human Resources Signature

Date