Employee Accident/Injury Report Form

*This form should be completed and signed by employee and supervisor as soon as practical after a call is placed to the **Medcor On-Line Injury Assessment Service at 1-800-775-5866***

General Information

Employee Name (Legal name)_____ Phone Number_____

Address_____ City, State, Zip_____

Social Security Number_____ Date of Birth_____ Sex (M/F) _____

Job Title_____ School_____

Time work began_____ Time work ended_____ Employment Date_____

Accident Information

Date of Accident_____ Time of Accident_____ Where did Accident Happen_____

Detailed Description of What Happened_____

Specifically, What You Were Doing_____

Precisely Describe the Pain You Felt_____

Specific Location of Pain_____

Nature of Injury_____

Was medical attention necessary?_____

If so, provide the name of the physician and clinic/hospital name_____

Did Accident Involve an Unsafe Act?_____ If so, describe_____

Did Accident Involve an Unsafe Condition?_____ If so, describe_____

Did Accident Involve a Company Policy?_____ If so, describe_____

Names of witnesses present_____

_____ _____ _____

Employee Signature Date Supervisor Signature