EMPLOYEE ACCIDENT REPORT FORM

To be completed and signed by employee and person receiving report

SUBMIT DIRECTLY TO ANN NOTTESTAD at the DISTRICT OFFICE

GENERAL INFORMATION			
Employee Name: (Last, First, Middle Initial)			Home Phone Number:
Home Address:			
Social Security #:	Job Title:		
Date of Birth:	Employment Date:		Sex (M/F):

ACCIDENT INFORMATION			
Date of Accident:	Time of Accident:	# Work Days Missed:	Facility Where Accident Occurred:
How Did the Injury or Illness Occur:			
Description of Injury or Illness (be as specific as possible):			
Describe, in Detail, Specifically What You Were Doing When Injury or Illness Occured:			
Specific Part of the Body Affected (i.e., lower back, right shoulder, left ankle):			
Did the Accident Involve an Unsafe Act?	Could This Accident Have Been Prevented?		
Names and Phone Numbers of Witnesses:			

TREATMENT	
Initial Treatment:	Hospitalization Required?:
Physician/Health Care Provider (Name, Address & Phone Number):	
Hospital (Name, Address & Phone Number):	
Employee Signature:	Date Reported:

FOR OFFICE USE	
Received By:	Date Received:
Claim Number:	Claim Representative: