

## Employee Accident Report

**Name:** \_\_\_\_\_ **Program/Job Title:** \_\_\_\_\_  
 Accident Occur on Agency Premises:  Yes  No **Accident Location:** \_\_\_\_\_  
 Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_  am  pm Sex:  F  M  
 Date Reported: \_\_\_\_\_ Witnesses: \_\_\_\_\_

**Accident Description:** \_\_\_\_\_

Injured Area	Indicate Area of Injury	Type of Injury
1 <input type="checkbox"/> Head 2 <input type="checkbox"/> Eye: L/R 3 <input type="checkbox"/> Shoulder L/R 4 <input type="checkbox"/> Arm L/R 5 <input type="checkbox"/> Elbow L/R 6 <input type="checkbox"/> Wrist L/R 7 <input type="checkbox"/> Hand L/R 8 <input type="checkbox"/> Finger: Specify _____ 9 <input type="checkbox"/> Back 10 <input type="checkbox"/> Chest 11 <input type="checkbox"/> Abdomen 12 <input type="checkbox"/> Pelvis 13 <input type="checkbox"/> Hip L/R 14 <input type="checkbox"/> Leg L/R 15 <input type="checkbox"/> Knee L/R 16 <input type="checkbox"/> Ankle L/R 17 <input type="checkbox"/> Foot L/R 18 <input type="checkbox"/> Toe: Specify _____ 19 <input type="checkbox"/> Other: _____		1 <input type="checkbox"/> Abrasion 2 <input type="checkbox"/> Amputation 3 <input type="checkbox"/> Bite: _____ 4 <input type="checkbox"/> Bruise 5 <input type="checkbox"/> Burn 6 <input type="checkbox"/> Concussion 7 <input type="checkbox"/> Cut/Laceration 8 <input type="checkbox"/> Foreign Body 9 <input type="checkbox"/> Fracture 10 <input type="checkbox"/> Hearing Impaired 11 <input type="checkbox"/> Infection 12 <input type="checkbox"/> Pain: _____ 13 <input type="checkbox"/> Puncture 14 <input type="checkbox"/> Rash/Dermatitis 15 <input type="checkbox"/> Respiratory 16 <input type="checkbox"/> Strain/Sprain 17 <input type="checkbox"/> Other: _____

Did injured employee miss work?  Yes  No Dates: \_\_\_\_\_

Form Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Program Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Our safety evaluations, reports and recommendations are made solely to assist your organization in reducing hazards and the potential of hazards and accidents. These recommendations were developed from conditions observed and information provided at the time of our visit. They do not attempt to identify every possible loss potential, hazard or risk, nor do they guarantee that workplace accidents will be prevented. These safety evaluations, reports and recommendations are not a substitute for ongoing, well-researched internal safety and risk management programs. This report does not warrant that the property inspected and its operations are compliant with any law, rule or regulation.

Investigation Report	
Cause Of Accident:	Source
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Corrective Action:	Action Taken
<div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div>	1 <input type="checkbox"/> House Keeping Improved 2 <input type="checkbox"/> Office Arrangement Changed 3 <input type="checkbox"/> Safety Equipment Purchased 4 <input type="checkbox"/> Replace Furniture or Equipment 5 <input type="checkbox"/> Training for Employee 6 <input type="checkbox"/> Maintenance & Upkeep Plan 7 <input type="checkbox"/> Safety Committee Referral 8 <input type="checkbox"/> Other: _____ 9 <input type="checkbox"/> Other: _____ 10 <input type="checkbox"/> Other: _____ 11 <input type="checkbox"/> Other: _____

Person responsible for corrective actions: \_\_\_\_\_

Target Completion Date \_\_\_\_\_

Date Corrective Actions Completed: \_\_\_\_\_

Signature of person responsible for corrective actions: \_\_\_\_\_

Additional Follow up Needed?     Yes     No

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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