Report of Accident / Illness

SAFETY & HEALTH MANAGEMENT INFORMATION

1. **Reason for Report:** ☐ **Accident** ☐ **Illness**
2. **Name:**____________________________
3. **SSN:**________________________
4. **Occupation:**________________________
5. **Phone:**______________________
6. **Date of Birth:**_______________________
7. **Sex:** ☐ **Male** ☐ **Female**
8. **Date / Time of Accident / Illness:**____________________ **Time:**______________ ☐ **AM** ☐**PM**

9. **Location of Incident:**

10. **Object or Substance that Directly Injured Employee?**

11. **Description of Incident:**

12. **Extent of Injury or Illness and Body Parts Affected:**

13. **Medical Treatment?** ☐ **Yes** ☐ **No**
14. **Lost time?** ☐ **Yes** ☐ **No**
15. **Return to Work Date:**______________________

Supervisor's Signature:____ **Date:**_________________

Title:____ **Phone:**_______________