

EMPLOYEE INCIDENT REPORT



CLIENT INFORMATION

NAME OF CLIENT		ADDRESS	
CONTACT	PHONE	FAX	

EMPLOYEE INFORMATION

INJURED PERSON'S NAME	SS#	AGE	BIRTHDATE	SEX (check) <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF HIRE
ADDRESS, CITY, STATE, ZIP CODE			TELEPHONE #	<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> ON-CALL	
			MARRIED <input type="checkbox"/> YES <input type="checkbox"/> NO	DEPENDENTS	TITLE / DEPARTMENT
EMPLOYEE'S WEEKLY/HOURLY WAGES	NORMAL SHIFT HOURS WORKED			EMPLOYEE'S LAST CHECK DATE	

INJURY INFORMATION

DATE OF ACCIDENT	TIME OF ACCIDENT	LOCATION OF ACCIDENT (Jobsite, Address, Etc.)
DESCRIPTION OF THE ACCIDENT		
LIST BODY PART OR PARTS INJURED	INITIAL TREATMENT GIVEN	
HAS THE EMPLOYEE RETURNED TO WORK (If yes, please indicate Return to Work date)	CAN LIGHT DUTY RESTRICTIONS BE ACCOMODATED	

PHYSICIAN/HOSPITAL INFORMATION

NAME, ADDRESS, AND PHONE OF TREATING PHYSICIAN/HOSPITAL
HOW WAS THE EMPLOYEE TRANSPORTED FOR TREATMENT

WITNESS INFORMATION

LIST OF WITNESSES TO ACCIDENT	WITNESS IN RELATION TO THE ACCIDENT
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I HEREBY CERTIFY THAT THE INFORMATION SHOWN ABOVE IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

EMPLOYEE SIGNATURE	DATE	SUPERVISOR SIGNATURE	DATE
ON A SCALE OF 1 TO 10, HOW WOULD YOU RATE THIS INJURY?			

** Be sure to fully complete this form before faxing. Fax the completed form to EP @ (904) 278-0558
 * Please also fax any medical information you may have regarding this employee/injury*