ACCIDENT/INJURY REPORT

To be completed for all accidents

Name of Injured: _______________________________ Date of Injury: _____________ Time of Injury: _____________

Location: ____

Street City State Zip

Actual:________ **Alleged:**_________ **Called MEDCOR: (800) 775-5866** Yes______ No______

Place where accident/injury occurred: (Be specific – for example: front yard, street, sidewalk, kitchen, office, etc.)

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____

Describe the Injury in detail: (size, laceration, abrasion, cut, puncture, etc.) ____

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PLEASE PUT AN "X" ON THE FIGURES TO THE RIGHT ON THE PART OF THE BODY THAT WAS INJURED.

Describe events that led up to the accident/injury: (What was going on?) ___________________

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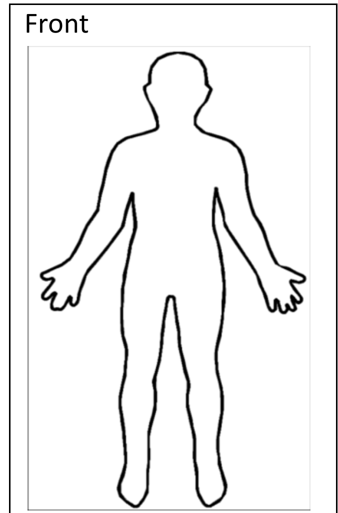
Front



Describe the accident/injury: (What happened – be specific, if using tools or equipment, name them & tell how they were being used.) ____

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Describe the action taken: (What did you do – for example, did you apply 1st Aid, call 911, assist the injured person in anyway? Be specific & describe actions in detail.) _________________________

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Describe results of action taken: (How did those involved respond?) _______________________

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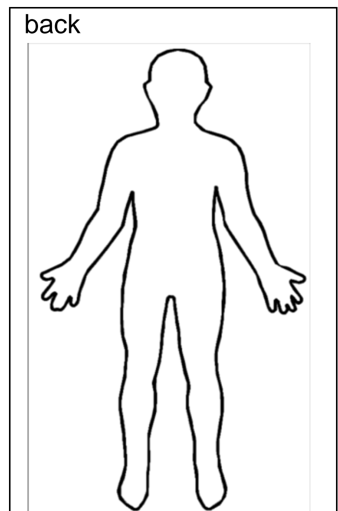
back



Witnesses present: ____

Signature of person completing form: ______________________________ **Date:** _________

Initials of Supervisor who read report: ______________________________ **Date:** _________

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Describe any follow-up action taken: ____

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COMPLETE BACKSIDE OF THIS FORM IF ADVANCED MEDICAL TREATMENT WAS RECEIVED

TO BE COMPLETED FOR MAJOR ACCIDENTS ON JOB SITE

(FOR WORKERS COMPENSATION)

Sex: _______ Age: _______ D.O.B. _________________ Marital Status: Yes No

SSN#______________________________

Number of hours worked per day: __________________ Number of hours worked per week: _____________________

When does shift begin?____

Job assigned when Injured: (For example; working in Day Program, working in consumer's home, working in community) ______________

____

____

Date Employer was notified: _______________ Name of Supervisor: ____

Were you able to continue working after accident?____________ If NO, date left work:______________________

Name of witnesses: ____

Have you returned to work? __________ If YES, date returned: ____

Did injury result in death? ________ Name, relationship, and address of closest dependent of deceased, if injury caused death: ____

IF YOU WENT TO A DOCTOR BECAUSE OF THE INJURY:

Name of doctor: ____

Name of hospital: ____

Doctor recommendations: ____

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____

Date of return to work, per doctor: ____

Signature of injured worker: ____ Date: _______________

Signature of Immediate supervisor: ____ Date: _______________

8/11 YS