

Accident Report

PLEASE PRINT

For business with 11 or more employees: Public Law 91-596 and OSHA require an individual form for each "recordable occupational injury," which is an injury that involves a fatality, lost workdays, job change, or medical treatment other than first aid. It must be kept on premises for at least five years following the end of the calendar year to which it relates. This form complies with OSHA's Supplementary Record of Occupational Injuries and Illness Form 101.

EMPLOYER:

Name of Company: _____	Date: ____ / ____ / ____
Physical Address: _____	File Number: _____
City: _____ State: _____ Zip: _____	
Mailing Address: _____	
City: _____ State: _____ Zip: _____	
This report was prepared by _____, whose job title is _____	

INJURED OR ILL EMPLOYEE:

Name: _____	Social Security Number: _____
Home Address: _____	Employee ID Number: _____
City: _____ State: _____ Zip: _____	Employee Payroll Number: _____
Age: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Insurance Account Number: _____
Employee's Regular Job Title: _____ Shift: _____	
Employee's Regular Department: _____	Supervisor: _____

THE ACCIDENT OR EXPOSURE TO OCCUPATIONAL ILLNESS:

If the accident or exposure occurred on employer's premises, give address or establishment in which it occurred. Do not indicate department or division within the plant or establishment. If accident occurred outside the employer's premises at an identifiable address, give that address. If it occurred on a public highway or at any other place which cannot be identified by number and street, please provide place references locating the place of injury as accurately as possible.

Place of Accident or Exposure: _____

City: _____ State: _____ Zip: _____ Date of Accident: ____ / ____ / ____

Was place of accident or exposure on employer's premises? Yes No

What was the employee doing when injured (be specific)?

Nature of injury or illness: _____

How did the accident occur (use separate sheet if necessary)?
