Employee Accident/Injury Report

Form must be submitted to Supervisor by the end of the work shift

Personal Information:

Name (Please print)	*Social Security Number*	*Date of Birth*
Street Address	*Mailing Address (if different)*	
City	*State* / *Zipcode*	*County*
Home Phone	*Work Phone*	*Cell Phone*
Email address		

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widow(er)
Sex: ___ Female ___ Male

Accident/Injury Information:

Did an injury occur? ___ Yes ___ No
(If no injury occurred, please complete the Near Miss Injury Report.)

Date of Accident/Injury	*Day of Week*	*Time Accident/Injury Occurred*	*a.m.*	*p.m.*

Location where accident/injury occurred:

Name of Location	*Department*			
Address	*City*	*State*	*Zipcode*	*County*
Specific Area (shredder,alligator shears, crane, bailer, etc.)	*Project/Task (loading/unloading mat'l., processing scrap, torching, etc.)*			

Part of machine, tool, object causing accident/injury: _____

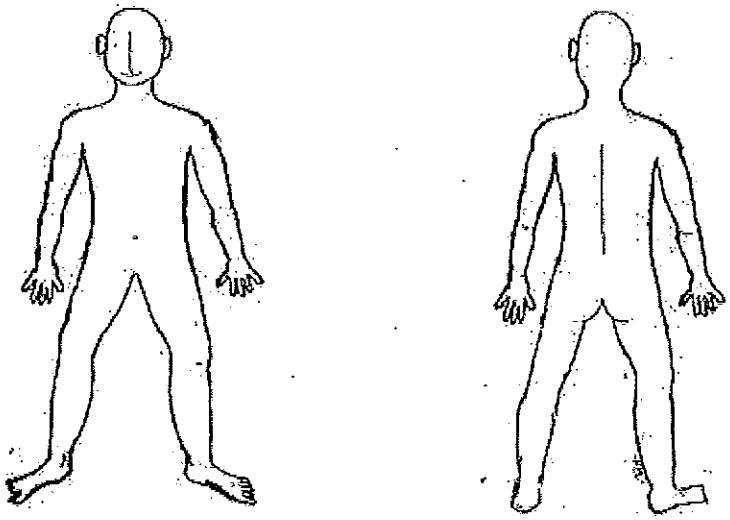
a. Was Safety Training conducted? ___ Yes ___ No
b. Was Safety Appliance, PPE, etc., used? ___ Yes ___ No

What task were you performing before the accident/injury occurred? _____

Full nature and exact location of injury: _____

Detailed description of how injury occurred:

Using an arrow, please indicate the location of the injury/injuries:



Employee Signature: _____ **Date:** _____

Notice of Disclaimer: In signing this Accident/Injury Report, I am stating that the facts related are true to the best of my knowledge. I also understand that willfully making a false claim in regards to a work-related injury will result in termination of my employment and possible criminal prosecution under NC Workers' Compensation Laws. I understand that, if I should require medical attention now or at a later time, I am required to contact my supervisor and go to an approved medical facility to fulfill Workers' Compensation requirements.

Supervisor Use Only

Was injured paid for the entire day? ___ Yes ___ No

Date disability began	*Day of Week*	*Hour of the day*		*a.m.*	*p.m.*
Name of Hospital		*Name of Physician*			
Address	*City*	*State*	*Zipcode*	*County*	
Phone		*Fax*			