

Accident/Illness Report

Please Print

This form complies with OSHA's Supplement Record of Occupational Injuries and Illnesses Form 101, and must be completed within six working days of an incident and kept in the establishment for five years to comply with Public Law 91-596 and OSHA requirements

Employer Information

Prepared by: _____ Job Title: _____ Date: ____ / ____ / ____

Company Name: _____ Case File #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Location: _____ City: _____ State: _____ Zip: _____
(IF DIFFERENT FROM MAILING ADDRESS)

Employee Information

Name: _____ Job Title: _____
Last First Middle

Home Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Gender: Female Male Birthday: ____ / ____ / ____

Department: _____ Employee/Payroll#: _____ Shift: _____

Social Security#: _____ Employee Insurance#: _____

Facts of Accident/Illness

Illness
 Yes No

Injury
 Yes No

Fatality
 Yes No

Date: ____ / ____ / ____

Did incident occur on employer's premise? Yes No If yes, address of plant/Facility: _____

_____ City: _____ State: _____ Zip: _____

Where on premises did incident occur? _____

If no address, where incident occurred: _____

(IF INJURY OCCURRED WHERE NUMBER AND STREET ARE UNIDENTIFIABLE PROVIDE PLACE REFERENCES)

_____ City: _____ State: _____ Zip: _____

Date of Accident/Illness: ____ / ____ / ____ Date Reported: ____ / ____ / ____ Time of Accident: _____ am

pm
What was employee doing when the accident or exposure occurred? (Be specific. If employee was using tools or equipment or handling material, name them and tell what employee was doing with them) _____

Explain how the incident occurred. List events that resulted in injury or illness, what happened, how it happened and name objects and how they were involved (use a separate sheet if necessary). _____

Describe the specific cause of the injury or illness: _____

Nature of Accident/Illness

Describe injury/illness and indicate the part of body affected (e.g. amputation of part, burn on left, middle finger, etc.) _____

Name object or substance which directly injured employee. _____

Date of initial injury/diagnosis: _____

Has any prior-related injury to affected area of body occurred at this company? Yes No

At previous companies? Yes No. In an environment other than work? Yes No

Were Bloodborne Pathogen Procedures implemented? Yes No Not Applicable

Additional Information

Days away from work: _____ Days of restricted work activity _____

Witnesses:

1. Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

2. Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Medical Attention

First Aid given by: _____ Date: ____ / ____ / ____ time: _____^{am}/_{pm} Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Doctor's Name: _____ Date: ____ / ____ / ____ time: _____^{am}/_{pm} Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Hospital Name: _____ Date: ____ / ____ / ____ time: _____^{am}/_{pm} Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Released Admitted Length of stay: _____

Notification

Family notified by: _____

Has the Personnel Department been contacted Yes No Date: ____ / ____ / ____

Has State Workers Compensation Agency been contacted? Yes No Date: ____ / ____ / ____

Has company Workers Compensation carrier been contacted? Yes No Date: ____ / ____ / ____

Has the cause of accident been corrected? Yes No Date: ____ / ____ / ____

If 1 or 2 employees were hospitalized, was OSHA notified within 24-hours? Yes No Date: ____ / ____ / ____

If fatality occurred or more than 3 employees are hospitalized, was OSHA notified within 8-hours? Yes No
Date: ____ / ____ / ____

Describe action to be taken, including preventive measures to ensure the accident does not occur again. _____

Approved by: _____ Date: ____ / ____ / ____

Supervisor on duty: _____ Date: ____ / ____ / ____