EMPLOYEE/SUPERVISORS ACCIDENT REPORT

CCMSI/SET SEG

Claimants Personal Information

Name: Last: _____ First: _____ Middle: _____

Address: _____

Social Security Number: ____ - ____ - ____

Job Position: _____

Date of Birth: _____ Date of Hire: _____

Home Phone: _____ Work Phone: _____

Marital Status: _____ Number of Dependents: _____ Gender: ○ Male ○ Female

Incident Information

Date of Injury: _____ Time: _____ Date Reported: _____ Location: _____

Drivers License #: _____ Drivers License State: _____

Accident Description/Summary of Incident:

_____

_____

_____ (Continue on back if necessary)

Initial Medical Treatment:

○ None Required ○ Refused ○ First Aid Only ○ Physician/Treatment Facility Visit ○ Emergency Room Visit

Witnesses: Name: _____ Phone: _____

Name: _____ Phone: _____

To be completed by Supervisor of Injured Employee

Describe Injury (include injured body part): _____

How Did Accident Happen? _____

_____

_____ (Continue on back if necessary)

Machine or Equipment involved? _____

Unsafe Acts Performed: _____ Unsafe Conditions Present: _____

Corrective Action Taken? _____

Has it been done? ○ Yes ○ No If no, give reason: _____

Signatures

Employee: _____ Date: _____

Supervisor's Signature: _____ Date: _____