

Employee Accident / Incident / Injury Report

This form must be completed in detail and signed by the injured employee.

FIRST NAME	Saint Dominic's Family Services	
LAST NAME	City – CIRCLE ONE Goshen Rockland Bronx	Department and/or House
Your Street Address	Supervisor's Name	
City, State, Zip		
Phone Number Where You Can be Reached – Cell and/or work	Job Title at Time of Injury	
Date of Hire	How Long in Current Position Yrs. Mos.	

Details of your Injury

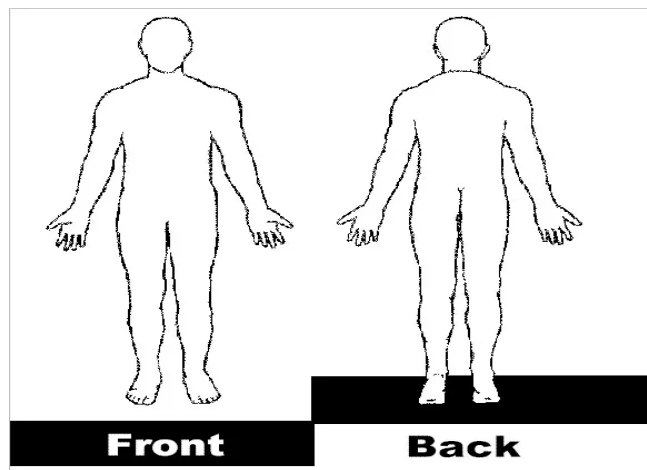
Date of Injury	Time of Injury AM / PM	Time you started work AM / PM
<u>Where</u> in the workplace did your injury occur?		
Was the cause of your injury due to human or machine error?		
<input type="checkbox"/> Human <input type="checkbox"/> Machine Error		
In your opinion, what was the cause of your injury?		
What safety measures do you think can be taken to prevent an injury of this type in the future?		

When were you first aware of this injury?

When did you notify your supervisor of your injury?

What part of your body is injured?

On the diagram provided below, please circle the parts of your body where you are experiencing pain due to this injury.



Did anyone witness your accident? If so, list the names of the witnesses.

Was anyone else injured in this incident? If so, list the names of the other injured people.

In the incident that caused your injury, was there damage to any property or equipment? If so, describe any damage.

I certify that the information contained in this report is true and correct.

I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.

I hereby authorize the release of all medical records relating to the above noted incident to my employer, his agent or insurance company.

Employee's Printed Name	Employee's Signature	Date

<u>EMPLOYEE</u> Name	Date of injury	Time of injury: AM / PM	
Did you stop working because of the injury? If so, on what date?	Were you doing your regular job?	Shift Start & End Times	
Describe the <u>accident</u>. Please be as detailed as possible.			
Describe the <u>injury</u> in detail, including part(s) of body affected and if any treatment received.			
Describe in detail any conditions which may have contributed to this accident. Describe any human error or machine error involved.			
Were there any witnesses to this injury? If so, please identify.			
<u>SUPERVISOR</u>			
Were you a witness to this injury?			
When you were first notified of this injury?			
Has the accident been discussed with employee to determine what steps can be taken to prevent a similar accident/injury?			
Has the problem been corrected?			
If so, how?			
Is there any additional information you feel may be beneficial?			
Supervisor's Printed Name	Supervisor's Signature	Department	Date