|  |
| --- |
| **EMPLOYEE INFORMATION** |
|  |
| **Full Name:** |       |
|  |  |
| **SSN:** |       | **Date of Birth:** |       | **Gender:** |  |
|  |
| **Address:** |       |
|  |
| **City, State, Zip:** |       |
|  |
| **Date Hired:** |       | **Employee Type:** |  |
|  |
| **Job Title:** |       | **Work Location:** |       |
|  |
| **Email:** |       | **Personal Phone:** |       |
|  |
| **Is the Employee covered by Board Insurance?** | [ ]  Yes [ ]  No |
|  |
| **Date of Incident:** |       | **Time of Incident:** |       | **Time Employee Began Work:** |       |
|  |
| **Date Reported to Supervisor:** |       | **Time Reported to Supervisor:** |       |
|  |
| **Incident Type:** | [ ]  Accident [ ]  Exposure |
|  |
| **Give a clear description of the incident and how it occurred:** |       |
|  |
| **Check Appropriate Action Required:** | [ ]  Ambulance Required [ ]  First Aid Only [ ]  No Treatment Needed [ ]  Emergency Treatment [ ]  Hospitalization [ ]  SCS Clinic |
|  |
| **Body Part(s) Injured:** |  | **Injury Type(s):** |       |
|  |
| **What caused the incident?** |       |
|  |
| **What object or substance directly harmed the employee?** |       |
|  |
| **OSHA Case Classification:** |  | **# Days Away From Work:** |       |
|  |
| **OSHA Injury Type:** |  | **Anticipated Return Date:** |       |
|  |
| **Actual Return Date:** |        | **Physical Assault?** | [ ]  Yes [ ]  No |
|  |
| **Was Personal Protection Equipment Required?** | [ ]  Yes [ ]  No |
|  |
| **Was Employee using Personal Protection Equipment?** | [ ]  Yes [ ]  No |
|  |
| **Reporting Location:** |       | **Report Prepared by:** |       |
|  |
| **Reporting Location Comments:** |       |

This form should be submitted to the main office for entry into the online Employee Accident Reporting system.