

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Employee ID No.: \_\_\_\_\_

Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Job Title: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Agency Address: \_\_\_\_\_  
Street, City, State Zip

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Location Where Incident Occurred: \_\_\_\_\_

Description of Incident (attach additional information if necessary):

Body Parts Injured: \_\_\_\_\_

Personal Protective Equipment (PPE) worn? Yes  No  N/A

If "YES", what type of Personal Protective Equipment was used?

\_\_\_\_\_

Seat Belt Properly Used: Yes  No  N/A

Opinion of Supervisor: Preventable  Non-Preventable

Witness of Accident	Address
_____	_____
_____	_____

Injured Employee Signature: \_\_\_\_\_

Supervisor (Please Print): \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_

Supervisor Phone Number: \_\_\_\_\_

Date Completed: \_\_\_\_\_