



EMPLOYEE ACCIDENT REPORT

(Please print all information clearly)

Store # _____ Date: _____ Time _____ a.m. / p.m.

Address: _____

Telephone: _____

Employee: _____

Address: _____

Telephone: _____

Nature of Injury: _____

Description of Accident: _____

What was employee engaging in at time of accident: _____

Was this part of the employee's job? _____ Yes _____ No

Was employee sent to designated clinic or facility? _____ Yes _____ No

Has employee returned to work: _____ Yes _____ No

Was employee wearing the required safety shoes? _____ Yes _____ No

Was employee following safety procedures? _____ Yes _____ No

Further information or comments: _____

Signed: _____ Date: _____

Owner/Manager on Duty

Signed: _____ Date: _____

Employee

THIS FORM MUST BE COMPLETED AT THE TIME THE ACCIDENT HAPPENED