

(INSERT YOUR COMPANY LOGO HERE)

ACCIDENT REPORT

Injured Employee's Name:	Injured Employee's cell #:	DATE OF INJURY:	Social Security Number:
Injured Employee's Home Address:		Address & Floor where accident occurred:	DREX Project Name:
			DREX Project Number:
Injured Worker's Company:		Foreman's Name (print):	

Time of accident?	Gender	Nature/Type of Accident:
	M F	

Receive Medical Care? Yes:___ No:___	If Yes - Medical Facility Name & Address:	If Yes - Name of Physician:
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What was employee doing just before the accident occurred?

Specific body part(s) affected/injured (ex. left hand index finger):

Witness Information	Describe in full detail how accident occurred. Please document who provided you with this information. Describe what the injured worker was doing at the time of this accident. As per _____, the following occurred:
Witness Name:	
Witness Company:	
Witness Cell #:	
Witness Name:	
Witness Company:	
Witness Cell #:	
Tool/Equipment Being Used:	
Company owner of tool/equipment:	
Tool/Equipment Being Used:	
Company owner of tool/equipment:	

List all Companies involved in the accident:	Did an ambulance or police come to the jobsite? Yes:___ No:___
	Did the injured individual stop working immediately? Yes:___ No:___
	Did injured return to the work that day? Yes:___ No:___ If yes, what time?: ___:___am/pm
	Did the injured individual receive first aid care while on site? Yes:___ No:___
	Did the injured individual employee go to hospital or doctor? Yes:___ No:___
	What time did the injured employee start work at? ___:___ am / pm ___
	How long was the injured employee employed at this jobsite? _____

Employee Compiling this Report (print): _____	Cell #: _____
Signature: _____	Date: ___ / ___ / ___