Accident Report

For businesses with 11 or more employees: Public Law 91-596 and OSHA require an individual form be completed for each "recordable occupational injury," which is an injury that involves a fatality, lost workdays, job change, or medical treatment other than first aid. It must be kept on premises for at least five years following the end of the calendar year to which it relates. This form complies with OSHA's Supplementary Record of Occupational Injuries and Illnesses Form 101.

Employer:				
Name of Company:				
Date Report Prepared:				
Location if Different than Mailing Address:				OSHA Case or File Number:
City:				
State		Zip:		There is a $250 penalty for failure to file accident reports within 28 days of employer's receipt knowledge of the accident.
Mailing address:				
City:				
State:		Zip:		
This Report was Prepared By:		Job Title:		Nature of Business:

Injured or Ill Employee Name:			
Social Security Number:			
Employee ID Number:	Employee Payroll Number:		
Home Address:			
City:	Age:	Birthdate:	Sex: ☐ Male ☐ Female
State: Zip:			
Employee's Regular Job Title:			
Shift:			
Employee's Regular Department:			
Supervisor:			

The accident or exposure to occupational illness:		
If the accident or exposure occurred on employer's premises, provide the address of establishment where it occurred. Do not indicate department or division within the plant or establishment. If accident occurred outside the employer's premises at an identifiable address, provide that address. If it occurred on a public highway or at any other place which cannot be identified by number and street, please provide accurate location reference:		
Place of Accident or Exposure:		
City:	State:	Zip:
Date of Accident:	Time of Accident:	
Was place of accident or exposure on employer's premises? YES NO		
What was the employee doing when injured (be specific)?		
Substance or object that caused the injury:		
How did the accident occur (use additional paper if necessary)?		

Occupational Injury or Occupational Illness:
Describe the injury or illness and indicate part(s) of body affected:
Name the substance or object which directly injured employee:
Date of injury or initial diagnosis of occupational illness: / /
Did employee die? YES NO
If so, give date of death: / /
Employee's regular department:
Number of work days missed:
Days of restricted activity:
Will further investigation be required? YES NO
Has employee returned to regular duty? YES NO
Light duty? YES NO Date: / /

Witness 1			
Name of Witness:			
Address of Witness:			
City:	State:	Zip:	Phone:

Witness 2			
Name of Witness:			
Address of Witness:			
City:	State:	Zip:	Phone:

Medical:				
Name of person administering first aide:				
Phone:				
Time first aide was administered:				
Was injured worker admitted to hospital?	YES	NO	Date:	/ /
Name of physician:				
Address of physician:				
City:	State:	Zip:		
If hospitalized, name of hospital:				
Address of hospital:				
City:	State:	Zip:		

Other:			
Has family been notified?	YES	NO	Date: / /
Has the appropriate department within company been notified?		YES	NO
Have appropriate state and federal agencies been notified?			
Describe actions taken to correct the cause and prevent the recurrence of another accident:			
Superior/ person in charge:			
Date of accident report:			
Department:			

_____ _____

Signature of person completing form Date