ACCIDENT REPORT FORM

Name of injured: _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Job Name: _____

Job Date (s): _____ Venue: _____

Employer: _____

Employer Representative: _____ Phone: _____

Payroll Company (if different): _____

Date of Injury: _____ Time of accident: _____

Address and description where accident occurred: _____

_____

_____

_____

Type of injury: _____

Details of accident (Describe completely what happened and how it happened. Use reverse side of form if needed):

_____

_____

_____

_____

_____

_____

ACCIDENT REPORT FORM
(continued)

List all others involved in this accident:

Name: _____

Address: _____

Phone: _____Relationship: _____

Name: _____

Address: _____

Phone: _____ Relationship: _____

Witnesses to this accident:

Name: _____

Address: _____

Phone: _____ Relationship: _____

Name: _____

Address: _____

Phone: _____ Relationship: _____

Treatment information (if available): Set Medic: _____

Treating Physician: _____ Phone: _____

Address: _____

Hospital: _____Phone: _____

Follow-up information (if available):

Disabling injury? Yes: _____ No: _____

Employee Returned to work? Yes: _____ No: _____

Date Returned to work: _____

Note: *This form is for the member and local union only. It is not designed to replace actual insurance forms. Please fill out the appropriate employer's insurance form as soon as possible.*