

# Employee Report of Accident

(To be filled out for all job related accidents)

Employee Name: \_\_\_\_\_ S.S.#: \_\_\_\_\_

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

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ : \_\_\_\_\_ A.M/P.M

Location of Accident: \_\_\_\_\_

Name of person you first reported this to: \_\_\_\_\_ Time: \_\_\_\_\_ : \_\_\_\_\_ A.M/P.M

Name of Supervisor: \_\_\_\_\_

Name of Witnesses (if any): \_\_\_\_\_  
\_\_\_\_\_

Describe how accident occurred: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Weather Conditions (if applicable): \_\_\_\_\_

Were you injured? \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain in detail your injury: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this an original injury or re-injury? \_\_\_\_\_ If re-injury, date of original injury: \_\_\_\_\_

Was first aid administered? \_\_\_\_\_ What type? \_\_\_\_\_

Date you sought Medical Attention: \_\_\_\_\_ Doctor's Name: \_\_\_\_\_

Office/Hospital: \_\_\_\_\_ Type of Treatment Required: \_\_\_\_\_  
\_\_\_\_\_

# Employee Report of Accident

(To be filled out for all job related accidents)

Date you will be able to return to work: \_\_\_\_\_

What is your present hourly rate of pay? \_\_\_\_\_

Did you miss any work? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, list date of absences: \_\_\_\_\_

What do you think could be done to avoid this accident from occurring again? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

.....

**Return this accident report to the Health & Safety Department as soon as possible. Remember, if this was an injury accident, a doctor's release to return to work is required.**

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health & Safety Signature: \_\_\_\_\_ Date: \_\_\_\_\_



6700 TOTEM BEACH RD. • TULALIP, WA 98271-9694

Department of Health & Safety of The Tulalip Tribes