

49er Shops Inc.

Accident Report

Date: _____

1. Please print clearly, or type.
2. Make sure to fill out front and back.
3. Submit a copy to Human Resources Director.

Name: _____

D.O.B.: _____

S.S. #: _____

Address: _____

City: _____

Zip: _____

Phone: _____

Dept: _____

Job Title: _____

Employee works ___ hours per day, ___ days a week, for a total of ___ hours per week.

What was the employee doing when injured? (Be specific. Identify tools, equipment or material employee was using.)

How did the accident occur? (Describe fully the events that resulted in injury. Tell what happened and how it happened.)

Did anyone witness the accident? Yes ___ No ___ If yes, Name: _____

Describe object or substance that directly injured the employee. (i.e. the machine the employee struck against or which struck him /her; the chemical that irritated; the object he/she was lifting or pulling when strain occurred.)

Describe injury or illness specifically, and part of body affected. (i.e. cut, sprain, fracture, rash etc...on the lower back, right hand, left eye...etc.)

Where was the employee sent?

1. Memorial Occupational Health Svcs. (check all that apply)

2. Other _____

If number 2, above, was checked, list medical group above, and Dr.'s name, address, and phone, here:

Date and Time of injury: _____

Time employee came to work: _____

Did employee complete scheduled work shift? Yes No

Did employee lose at least one full day's work after the injury? Yes No

Has employee returned to work? Yes No

Was employee given written notice of Worker's Compensation benefits, w/in 5 working days of the injury? Yes No

Was another person responsible? Yes No

If yes, state name: _____

What actions need to be taken to avoid this injury in the future?

Unit Manager's Signature: _____

Date: _____

Human Resources Use Only

Date of hire: _____

Hourly Wage: _____

Salary: _____

Class Code: Bookstore 8017 Clerical 8810 Food Service 9079

Referred to worker's Comp? Yes No

Revised 8-12-04