BEACH SHOPS

EMPLOYEE ACCIDENT REPORT

Please complete and return to Human Resources within 24 hours or the next business day following the accident.

_____ _____

EMPLOYEE'S NAME **DATE OF BIRTH**

Full Address : _____ **City/State :** _____ **Zip Code:** _____

Phone Number : _____ **Email Address :** _____

Home Department : _____ **Job Title :** _____

Employment Status (select one) : ☐ FULL-TIME ☐ PART-TIME ☐ STUDENT

Date of Injury : _____ **Time of Injury :** _____ **AM/PM** **Time Shift Began :** _____ **AM/PM**

Location of Accident : _____

Specific injury/illness and part of body affected. (e.g. Second degree burns on right arm, tendonitis on left elbow, lead poisoning, etc.)

Equipment, materials and/or chemicals the employee was using when the event or exposure occurred. (e.g. Knife, welding torch, ladder, etc.)

Specific activity the employee was performing when the event or exposure occurred. (e.g. Cutting fruit, loading boxes, cleaning the oven, etc.)

How did the injury/illness occur? Describe the sequence of events. Specify the object(s) or exposure which directly produced the injury/illness. (e.g. Worker stepped into the walk-in freezer and slipped on a piece of ice. As the worker was cleaning the oven, his right hand brushed up against the hot metal rack and burned right hand.)

Was another person involved in the injury/illness? ☐ YES ☐ NO

***If "Yes",* Name :** _____ **Phone Number :** _____

Were there any witnesses to the injury/illness? ☐ YES ☐ NO

If *"Yes",* please attach statements written from each witness.

Name: _____ **Phone Number :** _____

Name: _____ **Phone Number :** _____

Please check one of the following:

☐ I choose to accept medical treatment/evaluation and file a claim for the above noted condition and will go to the appropriate medical facility the Forty-Niner Shops, Inc. has designated.

☐ I choose to decline medical treatment/evaluation and filing a claim for the above noted condition. I understand that I do have the right to change my mind, within one-year from the date of injury, to file a Workers' Compensation claim. By signing this document, I also understand that should I decide to seek medical treatment for this injury/illness, I must immediately notify by Manager, Supervisor and/or Human Resources and go to the appropriate medical facility the Forty-Niner Shops, Inc. has designated.

Employee Signature : _____ **Date :** _____

Manager/Supervisor Signature : _____ **Date :** _____

Is video surveillance available? ☐ YES ☐ NO

If "Yes", is the video secured? ☐ YES ☐ NO

Did the employee complete their scheduled work shift? ☐ YES ☐ NO

Did the employee lose at least one full-day of work after the injury? ☐ YES ☐ NO

Has the employee returned to work? ☐ YES ☐ NO

Date of the employee's next scheduled shift: _____ **Hire Date :** _____ **Rate of Pay :** _____

Workers' Comp Code : ☐ 1001/CLERICAL ☐ 1004/RETAIL ☐ 1006/FOOD SERVICE ☐ 1007/MANUAL LABOR

Referred to Workers' Compensation Insurance Provider: ☐ YES ☐ NO

If "Yes", was the employee given Notice of Workers' Comp Benefits within 5 working days of the injury? ☐ YES ☐ NO

HR/Safety Committee Member Signature : _____ **Date :** _____