Employee Accident Report

Please complete and return, along with the DWC1 Form, to Human Resources within 24 hours or the next business day following the accident.

Employee's Name: _____ Date of Birth: _____

Street Address: _____ City: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Home Department: _____ Job Title: _____

Employment Status (Please Select): ☐ Full-time ☐ Part-time ☐ Student

Date of Injury: _____ Time of Injury: _____ Time Shift Began: _____

Location of Accident: _____

Specific Injury/Illness and part of body affect. Medical Diagnosis if available. (e.g. Second degree burns on right arm, tendinitis 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 stepping 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? (Select One) ☐ Yes ☐ No

If "Yes", Name of Other Person Involved: _____ Phone Number: _____

Was there any witnesses to the injury/illness? (Select One) ☐ Yes ☐ No

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

Witness 1 Name: _____ Phone Number: _____

Witness 2 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: _____

This section to be completed by Human Resources

Is video surveillance available? ☐ Yes ☐ No

Did the employee complete their scheduled work shift? ☐ Yes ☐ No

Has the employee returned to work? ☐ Yes ☐ No

Date of 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

Human Resources Signature: _____ Date: _____