



ACCIDENT INFORMATION REPORT

Return to Benefits Administration at +0602 or Fax to (330) 972-2336

A. THIS SECTION TO BE COMPLETED & SIGNED BY EMPLOYEE.

LAST NAME – FIRST NAME – MIDDLE NAME	EMPLOYEE ID#	DATE OF BIRTH	SEX	JOB TITLE
HOME ADDRESS	PHONE NUMBER	DEPT NAME	REPORTED TO DEPT. SUPERVISOR DATE: TIME:	
DATE & TIME OF INCIDENT	LOST TIME <input type="checkbox"/> YES <input type="checkbox"/> NO	RETURN TO WORK DATE	LOCATION OF ACCIDENT (Be Specific)	

EMPLOYEE'S STATEMENT - INDICATE HOW, WHEN, WHERE INJURY OCCURRED & DESCRIBE PART OF BODY INJURED:

NATURE OF INJURY: <input type="checkbox"/> Fracture <input type="checkbox"/> Laceration <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Burn <input type="checkbox"/> Foreign Body <input type="checkbox"/> Other _____	WAS FIRST AID GIVEN? <input type="checkbox"/> Yes <input type="checkbox"/> No DID YOU GO TO THE DOCTOR? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, PLEASE GIVE NAME. _____
NAME OF WITNESSES:	HAVE YOU FILED FOR WORKERS' COMPENSATION BEFORE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, WHERE?

I, the injured employee, herein certify that the information set forth above is true and correct to the best of my knowledge.

Employee Signature: _____ Date: _____

B. THIS SECTION TO BE COMPLETED & SIGNED BY SUPERVISOR.

DESCRIPTION AND APPARENT CAUSE OF ACCIDENT:

IF PROPERTY/EQUIPMENT INVOLVED, DESCRIBE DAMAGE:

WHAT WAS INJURED DOING WHEN INCIDENT OCCURRED?

CORRECTIVE ACTION RECOMMENDED:

WAS ACCIDENT DUE TO UNSAFE EQUIPMENT OR CONDITION?

Supervisor's Signature _____ Date: _____

C. THIS SECTION TO BE COMPLETED BY INVESTIGATOR.

HAS INVESTIGATION BEEN MADE? YES NO IF YES, ON WHAT DATE? _____

INVESTIGATOR'S REMARKS & RECOMMENDATIONS:

RECOMMENDATION FOR FILING CLAIM: APPROVED DISAPPROVED

Investigator's Signature _____ Date: _____