NAS-016

EMPLOYEE'S REPORT of ACCIDENT

(To be filled out for all occupation injuries)

Employee's Name: _____

Job Title: _____

Exact Time of Injury: _____ Date Injury: _____

Location where injury occurred: _____

Name of person to whom this incident was reported: _____

Name(s) of witness(es): _____

Summarize what happened: _____

_____

_____

EXPLAIN IN DETAIL: What part of your body was injured? **BE SPECIFIC** _____

_____

_____

Date and time you sought medical attention: _____

Whom did you see? _____ Office/hospital _____

Is this an original injury or a re-injury? _____

If a re-injury, when and where was previous injury incurred? _____

_____

_____

Who was your employer? _____ Claim Number: _____

Date and time you sought medical attention for original injury: _____

Whom did you see? _____ Office/hospital _____

Employee's Signature: _____ Date: _____

This form is to be returned to your supervisor as soon as possible.

Date supervisor received report: _____

Employees should make a prompt report to their immediate supervisor of each industrial injury or occupational illness, regardless of the degree of severity.