

Work Accident Information

Today's Date: ____/____/____

Name: _____

Date & Time of Accident: ____/____/____ ____:____ ____A.M. ____P.M.

Was your accident directly related to your work? ___Yes ___No

Briefly describe the events that occurred just before and during your accident:

Give the address where accident occurred (if other than employer's address):

Was anyone else present during your accident? ___Yes ___No

Did you report your accident to your employer? ___Yes ___No

What recommendations did your employer make just after your accident?

Has this type of accident happened to you before? ___Yes ___No

To the best of your knowledge, has this accident occurred in your workplace before?

___Yes ___No

In general:

Is your job physically stressful? ___Yes ___No

Is your job mentally stressful? ___Yes ___No

Is your workplace noisy? ___Yes ___No

Have you changed jobs in the last year? ___Yes ___No