

# Your Company

Phone: (503) 555-1212

Fax: (503) 555-1213

CCB# XXXXXX

## Employee Accident/Incident Report Form

Full name: \_\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

Complete Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

About the Accident/Incident . . .

Time and Date of Occurrence: \_\_\_\_\_

Location: \_\_\_\_\_

What injuries are being reported? \_\_\_\_\_

\_\_\_\_\_

How did the accident occur? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Witnesses to the accident: \_\_\_\_\_

\_\_\_\_\_

Treatment or First Aid provided: \_\_\_\_\_

\_\_\_\_\_

By signing below, employee consents to the release of medical charts, reports, X-rays, diagnoses, and other information to the company or it's authorized representatives from any health care provider rendering treatment or providing consultative or other services in conjunction with the diagnosis and treatment of the injury described above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Your Address**