

# EMPLOYEE/SUPERVISORS ACCIDENT REPORT

CCMSI/SET SEG

## Claimants Personal Information

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Job Position: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Number of Dependents: \_\_\_\_\_

Gender:  Male  Female

## Incident Information

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_ Date Reported: \_\_\_\_\_ Location: \_\_\_\_\_

Drivers License #: \_\_\_\_\_ Drivers License State: \_\_\_\_\_

Accident Description/Summary of Incident:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (Continue on back if necessary)

Initial Medical Treatment:

None Required  Refused  First Aid Only  Physician/Treatment Facility Visit  Emergency Room Visit

Witnesses: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## To be completed by Supervisor of Injured Employee

Describe Injury (include injured body part): \_\_\_\_\_

How Did Accident Happen? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_ (Continue on back if necessary)

Machine or Equipment involved? \_\_\_\_\_

Unsafe Acts Performed: \_\_\_\_\_ Unsafe Conditions Present: \_\_\_\_\_

Corrective Action Taken? \_\_\_\_\_

Has it been done?  Yes  No If no, give reason: \_\_\_\_\_

## Signatures

Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_