ST. JOHN FISHER ACCIDENT REPORT FORM

SECTION 1: INJURED PERSON’S REPORT (Please use the back of the report for more room.)

Full Name of injured person: ___________________________  Department: __________________  Title: ______________

Address City/State/Zip: __________________________________________________________ Phone #: ______________________

Date of Birth: ______________ Date hired: ______________ (Please check) Male__  Female__

Days normally worked: ______________  Hours worked: __________ Shift ______

Injury Date: ______________ Day of Week: ______________ Occurrence time: _______ a.m. _______ p.m.

Date employer notified: ______________ Person who received the first notice? __________________________

Accident Description – describe how the incident had occurred: ____________________________________________
______________________________________________________________________________________________

Nature of injury - state the nature of injury and part(s) of body affected (ex. right knee, lower back, etc.)
______________________________________________________________________________________________
______________________________________________________________________________________________

What were you doing just before the accident occurred? __________________________________________________

Where did the accident occur (exact location) and facility? ______________________________________________

How did the accident occur? ______________________________________________________________________

What factors led up to or contributed to the accident? ____________________________________________________

What were the weather conditions on the date of your accident? __________________________________________

What tools, equipment or substance was being used? ____________________________________________________

Was time away from work necessary? ____Y   ____N  Last Day worked: ________ Disability begin date: ________

Name and address of any witnesses: ________________________________________________________________

Have you been provided medical treatment? ____Y   ____N  Will you need medical treatment? ____Y   ____N

Did you receive care on campus? ____Y   ____N

If treatment was given away from the worksite, where was it given? Please provide the Name/Address of provider:
______________________________________________________________________________________________

Were you treated in the emergency room? ____Y   ____N  Were you hospitalized overnight as an in-patient? ____Y   ____N

EMPLOYEE SIGNATURE: ___________________________________________  DATE: ______________________

Revised May 2011
Please complete this form and return to the Human Resources Office within 24 hours of the time of the accident

SECTION II SUPERVISOR’S REPORT: PLEASE VERIFY THE INFORMATION IN SECTION 1

When did you first know of the injury? ____________________________

List the direct cause(s). List both unsafe actions and unsafe conditions. ____________________________

List the root cause(s). ____________________________________________

List the actions that have been or will be taken to remove direct causes listed above by whom and when they are or will
be done. ________________________________________________________

What additional actions need to be taken in the future? ____________________________

Has the employee returned to work? ________

If yes, what date? ___________  Regular Duty___ Light Duty___

IMMEDIATE SUPERVISOR’S SIGNATURE: ____________________________  DATE: ___________________