Where Culture & Engagement Drive Performance

SSO Staff Incident Report Form

PLEASE PRINT CLEARLY:

State of Employment: _____________ Policy Number: __________________

Date of Accident_________ Time of Accident: ________a.m. ______p.m

Unit or Site

____

A. EMPLOYER INFORMATION (Exact location where employee works)

____

Address:

____

City, State or Zip Code: _ ____

Business Phone Number & Extension: ______________________ Ext. _____

Nature of Business:

____

B. EMPLOYEE INFORMATION

Name: ____

Address: ____, __________________________________

City, State and Zip Code: ____

Residence Phone: ________________________

Business Phone Number & Extension________________ Ext. ________

Birthdate: ________________________ or Age: ___________

Social Security #: ____

Sex: ____________ Number of Dependents: __________________

Marital (circle one) Married Single Divorced Widowed Unknown

Occupation: ____

Department: ____

Where Culture & Engagement Drive Performance

Length of Time employed: Years: _________ Months: __________ or Date of hire: _____

Average Weekly wage: _______________________

Was work time lost:

(circle one) Hourly

Start date of disability______________________________________ Date return to work_________

C. ACCIDENT INFORMATION

Time of accident: ________________ a.m./p.m.
Date Injury Reported: __/_____/___ Human Resources was notified: ___/___/___

Was accident at employer's premises:

If No, give address:
____

City, State &Zip: ____

Description of accident:
____
____
____
____

Describe injury or illness:

Surgery required as a result of accident: (circle one)

Body part injured? ____

What was the injured employee doing?
____

What was the direct cause of injury? (machine, tool, object or substance)

____

Did individual receive medical attention? (circle one) Yes No
If Yes, please describe:
____
____
____

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D. PHYSICIAN/ HOSPITAL INFORMATION

Name: ____

Address:

____

City, State and Zip:

____

Business Phone Number & Extension: (_____)______-__________ Ext._______

E. WITNESS INFORMATION

Name: Reported to: Name _________________Title _______________________________

Associates who witnessed this:____

Address: ____

____

City, State and Zip Code:

____

Business Phone Number & Extension: (_____)______-_________ Ext______

F. General Information

Name & Title of person reporting accident:

____

General remarks:

____

____

____