

Case: _____ Control: _____

Date Received: _____

Type/Source: _____ / _____

Org. Code: _____

Report of Accident/Illness

SAFETY & HEALTH MANAGEMENT INFORMATION

TO BE COMPLETED BY EMPLOYEE

1. Reason for Report: ☐ Accident ☐ Illness

2. Name: _____ 3. SSN: _____
(Last, First, M.I.)

4. Occupation: _____ 5. Phone: _____

6. Date of Birth: _____ 7. Sex: ☐ Male ☐ Female

8. Date/Time of Accident/Illness: _____ Time: _____ ☐ AM ☐ PM

9. Duty Station Address:

10. Location of Incident:

11. Description of Incident:

12. Extent of Injury or Illness and Body Parts Affected:

Signature: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR

13. Medical Treatment? ☐ Yes ☐ No 14. Lost Time? ☐ Yes ☐ No

15. Investigator's Name: _____ 15. Investigation Date: _____

16. Findings:

17. Amount of Property Damage: \$ _____

18. Corrective Action:

19. Completion Date: _____ ☐ Estimated ☐ Actual

Investigator's Signature: _____ Date: _____

Title: _____ Phone: _____