

CS&A Insurance EMPLOYEE INCIDENT REPORT

BUSINESS NAME	\checkmark					
CONTACT NAME CONTACT PHONE CONTACT EMAIL TODAY'S DATE DATE OF LOSS CLAIMANT/EMPLOYEE NAME Injured Employee Information First Name: Last Name: M/F: SS #: Address: Phone number: Job Title: Date of Hire: Full Time / Part Time: Incident Information Date of Incident: Date of Incident: Time of Incident: Location of Incident: Time of Incident: Control of Incident: M/F: Full description of injuries including affected body part: Supervision of injuries including sequence of events preceding the accident: Supervisor: Name: Job Title: Witness: Name: Phone: Name: Phone: Phone: Initial Treatment: Employee Missed Work? Location of Treatment:	BUSINESS NAME	Ξ				
CONTACT EMAIL TODAY'S DATE DATE OF LOSS CLAIMANT/EMPLOYEE NAME Injured Employee Information Last Name: Last Name: First Name: Date of Birth: M/F: SS #: Address:	CONTACT NAME			CONTACT PHONE TODAY'S DATE		
DATE OF LOSS CLAIMANT/EMPLOYEE NAME Injured Employee Information Last Name:						
Injured Employee Information Last Name: First Name: Date of Birth: M/F:SS #:Address: Address: Phone number:Job Title: Date of Hire:Full Time / Part Time: Incident Information Date of Incident:Full Time of Incident: Location of Incident: Full description of injuries including affected body part: Full description of injuries including sequence of events preceding the accident: Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, Supervisor: Name:Job Title:Phone: Name:Phone:Phone:						
Last Name: First Name: Date of Birth: M/F: SS #: Address:	DATE OF LOSS _		CLAIMANT/EMPLOYE	YEE NAME		
Date of Birth: M/F: SS #: Address:	Injured Emp	loyee Informatio	on			
Address:	Last Name:			First Name:		
Phone number: Job Title: Date of Hire: Full Time / Part Time: Incident Information Date of Incident: Location of Incident: Address where incident occurred:	Date of Birth	.:	M/F:	SS #:		
Phone number:	Address:					
Incident Information Date of Incident:Time of Incident: Location of Incident:Time of Incident: Address where incident occurred:Address where incident occurred: Full description of injuries including affected body part: Full description of injuries including sequence of events preceding the accident: Employee's account, including sequence of events preceding the accident: Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, Supervisor: Name:Job Title: Witness: Name:Phone: Name:Phone: Initial Treatment:Employee Missed Work?Location of Treatment:						
Date of Incident:	Date of Hire:		Full Time / Part Time:			
Location of Incident:	Incident Info	ormation				
Address where incident occurred:	Date of Incident:		Time of Incident:		AM/PM	
Full description of injuries including affected body part: Employee's account, including sequence of events preceding the accident: Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, Supervisor: Name: Job Title: Phone: Name: Phone: Name: Phone: Initial Treatment: Employee Missed Work?	Location of I	ncident:				
Employee's account, including sequence of events preceding the accident: Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, on the second seco	Address whe	re incident occu	rred:			
Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, a Supervisor: Name: Job Title: Witness: Name: Phone: Name: Phone: Name: Phone: Initial Treatment: Employee Missed Work? Location of Treatment:	Full descripti	ion of injuries inc	luding affected bod	ly part:		
Supervisor: Name: Job Title: Witness: Name: Phone: Name: Phone: Phone: Initial Treatment: Employee Missed Work? Location of Treatment:	Employee's a	account, includin	g sequence of event	s preceding the accident:		
Witness: Name: Phone: Phone: Name: Phone: Phone: Phone: Initial Treatment: Employee Missed Work? Location of Treatment:	Basic cause a	and contributory	causes. Explain full	y unsafe act, unsafe condition, personal fact	or, other:	
Name: Phone: Name: Phone: Initial Treatment: Employee Missed Work? Location of Treatment:	Supervisor:	Name:		Job Title:		
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