CS&A Insurance

EMPLOYEE INCIDENT REPORT

BUSINESS NAME _____

INSURANCE CO. _____ **POLICY #** _____

CONTACT NAME _____ **CONTACT PHONE** _____

CONTACT EMAIL _____ **TODAY'S DATE** _____

DATE OF LOSS _____ **CLAIMANT/EMPLOYEE NAME** _____

Injured Employee Information

Last Name: _____ First Name: _____

Date of Birth: _____ M/F: _____ SS #: _____

Address: _____

_____

Phone number: _____ Job Title: _____

Date of Hire: _____ Full Time / Part Time: _____

Incident Information

Date of Incident: _____ Time of Incident: _____ AM/PM

Location of Incident: _____

Address where incident occurred: _____

_____

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, other:

_____

_____

Supervisor: Name: _____ Job Title: _____

Witness: Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Initial Treatment: _____ Employee Missed Work? _____

Location of Treatment: _____

Form Completed By: _____ Date Form Completed _____