

## 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:	<b>BUSINESS NAME</b>	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:		
Name:Phone: Initial Treatment:Employee Missed Work? Location of Treatment:	Witness:	Name:		Phone:		
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Initial Treatment:Employee Missed Work? Location of Treatment:		Name:				
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