EMPLOYEE INFORMATION

Employees must report any accident/incident to their supervisor immediately, and complete a written statement in support of their report. Please fill in the following as completely as possible. You must contact Human Resources (x3837) prior to obtaining voluntary outside medical attention.

Employee Name:

Address:

City:

State & Zip:

Phone #:	DOB:	Male Female

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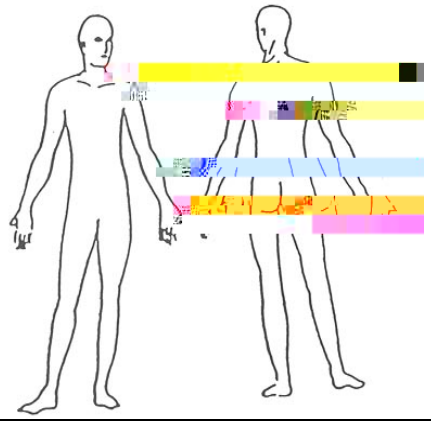
ACCIDENT INVESTIGATION (CONTINUED)

Part of body: Employees involved: Activity being performed:	Please describe the incident to the best of your ability. What were you doing at the time of the incident?

Do you have any suggestions to prevent this type of accident from recurring?

Do you have any discomfort? Y/N Please describe the type of discomfort you are feeling:

Please identify the area in which you received an injury and any areas where you are feeling pain: Specify front or back. 	If your injury is serious and you require emergency medical treatment, contact SECURITY (x3500) and emergency medical transport will be arranged for you. If the accident/incident involved chemical exposure, a copy of the MSDS sheet must be provided to the hospital. All employees have the right to see their own physician and/or obtain a second opinion after 10 days from the date of the incident.

Individual completing report (signature):	Date: