ACCIDENT REPORT

Company: _____ Phone: _____

General Manager: _____ Cell: _____
Email address:

Name of the Employee: _____ Phone: _____

Job Position: _____ Date of accident: _____

Time of Accident: _____ Witness: Yes No

Part of the body injured: _____

Area where the accident occurred: _____

Other employees involved? Yes No

Name of other employee: _____ Phone: _____

Specific activity the employee was performing when the accident occurred:

_____

_____

_____

Was the employee transported by ambulance? Yes No

Name of the clinic or hospital where employee went: _____

Phone number of the clinic: _____

Was the employee given the DWC-1 form? Yes No

Can the employee be accommodated if modified duties are recommended? Yes No

Name of the assistant completing this form: _____

Please email completed form to: mario@gfgnow.com