PrestigePEO℠

# INCIDENT REPORT

Employee Name

## CLIENT INFORMATION

Client Name: Supervisor's Name:

Client Address: City:

State: Zip Code: Work Phone:

## ACCIDENT INFORMATION

Accident Location Name:

If not at regular work location, please indicate where the accident occurred:

Was employee injured in regular job? ☐ Yes ☐ No ☐ Unknown

If Unknown, please explain

Date of accident: Time of accident: Accident Reported to:

Describe the nature of injury/injuries:

Body Part Injured:

Cause of Accident (please give specifics):

What was the employee doing at the time of injury?:

Has employee missed time from work, or are they expected to? ☐ Yes ☐ No ☐ Unknown If yes, how many days?: ________

Has the employee returned to work? ☐ Yes ☐ No ☐ Unknown The date returned or expected to return: ________

Last Day Worked: ________ Did Employee receive medical treatment: ☐ Yes ☐ No ☐ Unknown

Initial Treatment (first aid/clinic/ER): ________

Witness(es) of the Accident: ________ Time Employee left work: ________

Taken by Emergency transportation (i.e. ambulance)?: ☐ Yes ☐ No ☐ Unknown

Was employee paid in full for the day of the accident?: ☐ Yes ☐ No ☐ Unknown

Work Hours: ________ to ________ Regular Days Off (check): ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

Regular Hours Worked: ________ ☐ Full-Time ☐ Part-Time

Medical Facility name: ________

Address: ________ City: ________

State: ________ Zip Code: ________ Phone Number: ________

Treating Physician: ________ Date Admitted: ________

**Incident Added to OSHA log:** ☐ **Yes** ☐ **No**

________________________________
Supervisor's name (please print)

________________________________ ________________
Supervisor's Signature: Date