



# EMPLOYEE ACCIDENT REPORT

## Employee Information

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Date \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip: \_\_\_\_\_

DoB: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Gender: M F

## Accident Information

Accident Date: \_\_\_\_\_ Time: \_\_\_\_\_ am pm Time Shift Began \_\_\_\_\_ am pm

Location (facility) \_\_\_\_\_ Area \_\_\_\_\_ (unit, bldg, etc)

Injury Type		Area of Injury		Type of Incident			
<input type="checkbox"/>	Fall	<input type="checkbox"/>	Head	<input type="checkbox"/>	Face	<input type="checkbox"/>	Struck against
<input type="checkbox"/>	Puncture	<input type="checkbox"/>	Neck	<input type="checkbox"/>	Chest	<input type="checkbox"/>	Struck by
<input type="checkbox"/>	Foreign body	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	Groin	<input type="checkbox"/>	Caught between
<input type="checkbox"/>	Sprain/Strain	<input type="checkbox"/>	Coccyx	<input type="checkbox"/>	Lower back	<input type="checkbox"/>	Slip/trip
<input type="checkbox"/>	Burn	<input type="checkbox"/>	Upper back			<input type="checkbox"/>	Disease Exp
<input type="checkbox"/>	Bite	<input type="checkbox"/>	Ear	<input type="checkbox"/>	R L	<input type="checkbox"/>	Over Exertion
<input type="checkbox"/>	Contusion/Bruise	<input type="checkbox"/>	Eye	<input type="checkbox"/>	R L	<input type="checkbox"/>	Inhale / Swallow
<input type="checkbox"/>	Laceration/Cut	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	R L	<input type="checkbox"/>	Heat / Elect / Flash
<input type="checkbox"/>	Eye Injury	<input type="checkbox"/>	Arm	<input type="checkbox"/>	R L	<input type="checkbox"/>	Chemical
<input type="checkbox"/>	Rash	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	R L	<input type="checkbox"/>	Patient / Inmate
<input type="checkbox"/>	Broken / Dislocated	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	R L	<input type="checkbox"/>	Sharps
<input type="checkbox"/>	Amputation	<input type="checkbox"/>	Hand	<input type="checkbox"/>	R L	<input type="checkbox"/>	Splash / Skin Exp
<input type="checkbox"/>	Bloodborne Exposure	<input type="checkbox"/>	Hip	<input type="checkbox"/>	R L	<input type="checkbox"/>	Other (describe below)
	Source <input type="checkbox"/> Unknown	<input type="checkbox"/>	Leg	<input type="checkbox"/>	R L		
	<input type="checkbox"/> Known	<input type="checkbox"/>	Knee	<input type="checkbox"/>	R L		
	Source tested? Y N	<input type="checkbox"/>	Ankle	<input type="checkbox"/>	R L		
	Give source info below	<input type="checkbox"/>	Foot	<input type="checkbox"/>	R L		

Other: \_\_\_\_\_

Did you seek care at the time of the accident?  Yes  No Was AMP office notified?  Yes  No

If yes, where and what treatment was received? \_\_\_\_\_

State exactly how and what you were doing at the time of the incident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Was this part of normal job duty?  Yes  No What could have been done to prevent this? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Names of persons observing or involved in accident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Employee Signature: \_\_\_\_\_

**Fax completed form to AMP within 72 hours of accident - 405-943-7947 or 888-575-7374**