



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