

EMPLOYEE INFORMATION	
EMPLOYEE'S NAME: _____	ID/CLOCK NO.: _____
DIVISION: _____	DEPARTMENT: _____
AGE: _____	CLASSIFICATION: _____

ACCIDENT INFORMATION		
DATE: _____	TIME: _____	PLACE: _____
ACCIDENT FIRST REPORTED TO: _____		
WITNESSES: _____		
DESCRIBE HOW ACCIDENT OCCURRED: _____		
TYPE OF INJURY: _____	PART OF BODY: _____	
MEDICAL TREATMENT BY: _____		
LOSING TIME FROM WORK DUE TO INJURY? YES NO		
CAUSE OF ACCIDENT (CHECK ANY THAT APPLY):		
_____ INADEQUATE SUPERVISION	_____ CARELESSNESS	
_____ IMPROPER/INADEQUATE INSTRUCTIONS	_____ POOR JUDGEMENT	
_____ FAILED TO FOLLOW ORDERS	_____ FAILURE TO USE SAFETY EQUIPMENT	
_____ UNSUITED FOR POSITION	_____ DANGEROUS CONDITION	
_____ POOR WORK ATTITUDE	_____ DEFECTIVE EQUIPMENT	
CAUSED BY ANOTHER PARTY (explain): _____		
OTHER (explain): _____		
ACTION TAKEN TO PREVENT SIMILAR ACCIDENT (CHECK ANY THAT APPLY):		
_____ INSTRUCTED EMPLOYEE	_____ REPLACED/REPAIRED EQUIPMENT	
_____ TRAINING	_____ CHANGED OF JOB DUTIES	
_____ CORRECTED HAZARD/CONDITION	_____ OTHER (explain): _____	

HAS THIS EMPLOYEE HAD SIMILAR ACCIDENTS? YES NO
EXPLAIN: _____

DATE	SUPERVISOR'S SIGNATURE	TITLE
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Complete this form for any accident involving an employee, and return to Human Resources, Risk Management Division.

In case of an emergency, contact Risk Management at 305-673-7524 or Fax: 305-673-7023.

DISTRIBUTION: 1-RISK MANAGEMENT, 2-EMPLOYEE'S DEPARTMENT FILE, 3-DEPARTMENT'S ACCIDENT FILE