**EMPLOYEE ACCIDENT REPORT**
(*On-the-job injuries*)

NAME_____ PHONE # (  ) _____ WORK _____
_____
HOME ADDRESS _____ CITY _____STATE_____ZIP CODE_____
SSN _____DOB_____DATE HIRED_____
F/T_____P/T_____DEPARTMENT_____

JOB TITLE_____COST CENTER _____
MALE_____ FEMALE _____

DATE OF INCIDENT_____ LOCATION _____ TIME _____
DID EMPLOYEE RECEIVE MEDICAL TREATMENT _____YES _____ NO HOSPITALIZED _____ YES _____ NO
TREATING PHYSICIAN _____ EMERGENCY ROOM TREATMENT _____ YES _____ NO
NAME OF TREATING FACILITY _____
WHAT WAS EMPLOYEE DOING BEFORE INJURY OCCURRED?
_____
_____
HOW DID INJURY/EXPOSURE OCCUR? _____
_____
_____
TO WHOM WAS INCIDENT REPORTED_____ SUPERVISOR'S NAME _____
NAME OF WITNESS _____
NATURE AND PARTS OF BODY INJURED (RT/LF SIDE, HAND, KNEE, ETC.) _____
_____

DID EMPLOYEE LOOSE TIME FROM WORK _____ YES _____ NO HOW MUCH _____HOURS _____ MINUTES
FIRST FULL DAY MISSED _____
***(If yes, must be reported immediately to Workers' Compensation Office)***

WHAT IS BEING DONE TO PREVENT REOCCURRENCE? _____
_____
_____

_____ _____
***Employee's Signature & Date*** ***Supervisor's Signature & Date***

**ALL REFERRALS AND SPECIALIZED TREATMENT MUST BE AUTHORIZED & APPROVED**
Original/White Copy) – Risk Management Office
Yellow Copy – Medical Treatment Facility
Pink Copy – File Copy for Employee's Department

**FAX IMMEDIATELY TO (229) 878-3120 or (229) 878-3149**

FORM WC-7