Perform Air International

Employee Accident and Injury Reporting Form

Date of accident or injury: _____ Time: _____ am pm

Location / Address: _____

Name of employee injured or involved in accident (if more than 1 please use additional form/forms): _____ Job Title: _____

Supervisor's Name: _____

Person initiating this form (if other than supervisor): _____

What specific part of the body was injured? Describe in detail:

_____

_____

What was the nature of the injury? Describe in detail:

_____

_____

Describe fully how the accident happened. Where did it happen? What was the employee doing prior to the event? What equipment, tools were being used, etc?

_____

_____

_____

_____

Was employee utilizing the required PPE correctly? Yes ___ No ____

Names of all witnesses:

_____ _____

_____ _____

_____ _____

Did the employee require first aid? If so, please describe below:

_____

_____

_____

Did employee require professional medical attention? If so please list:

Doctor's Name: _____ Facility Name: _____

Did the employee request or require assistance getting to faculty? Yes ___ No ___

Name of employee / person who provided assistance, if provided:

_____

Was the employee offered first aid or professional medical attention and refused?

Yes ___ No ____

Signature of employee acknowledging refusal of medical treatment:

_____ Date: _____

Witness: _____ Date: _____

Signature of *Human Resources Manager*, or designee, verifying information:

_____ Date: _____

Signature of employee involved verifying information:

_____ Date: _____