EMPLOYEE INJURY REPORT

ACI Support Specialists, Inc.

PART 1 EMPLOYEE MUST COMPLETE AND ANSWER ALL QUESTIONS

Name: _____

Address: _____

_____

Phone: _____

DOB: _____

SS#: _____

Length of Employment: _____

Today's Date: _____

Region: _____

Supervisor: _____

Date of Accident: _____

Time of Accident: _____ AM/PM

Day of Accident: (circle appropriate day)

Sun M T W Th F Sat

Time started work: _____ AM/PM

Exact location where accident occurred: _____ County: _____

Employee's Complete Description of Accident: (Explain in detail)

_____

_____

_____

_____

_____

_____

Description of Injury: (Give details including part of body injured) _____

_____

_____

Did Anyone Witness This Accident? ☐ Yes ☐ No If yes, please give names:

_____ _____

_____

Employee's Signature

PART 2 TO BE COMPLETED BY SUPERVISOR WHO RECEIVED REPORT

Date and Time Injury was Reported: _____ Time/Days missed from work: _____

Hours Worked Each Day by Employee: _____ # of Days Worked Each Week: _____

Did Employee Require Medical Attention: ☐ Yes ☐ No If yes, Where?: _____

_____

Supervisor's Printed Name Signature Date