

EMPLOYEE INJURY REPORT

ACI Support Specialists, Inc.

PART 1 EMPLOYEE MUST COMPLETE AND ANSWER ALL QUESTIONS

Name: _____

Today's Date: _____

Address: _____

Region: _____

Supervisor: _____

Date of Accident: _____

Phone: _____

Time of Accident: _____ AM/PM

DOB: _____

Day of Accident:

SS#: _____

Sun M T W Th F Sat

Length of Employment: _____

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: _____

Hours Worked Each Day by Employee: _____

of Days Worked Each Week: _____

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

Supervisor's Signature

Date