Sevier County Workers Compensation Accident Form

THIS FORM MUST BE COMPLETED AND RETURNED TO THE HR OFFICE WITHIN 24 HOURS

EMPLOYEE NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

DATE OF INCIDENT	TIME OF INCIDENT	TIME WORK BEGAN

Where Incident Occurred/Address _____

Describe Incident giving full details

*Injured while performing regular work duties ___YES ___NO, if no explain why

*Was safety equipment provided ___YES ___NO ___NOT REQUIRED

Part of Body Injured

___Head
___Eyes
___Nose
___Mouth
___Ear
___Neck
___Shoulder
___(Upper) Back
___(Lower) Back
___Chest
___Arms
___Wrist
___Hand
___Finger
___Thigh
___Knee
___Leg
___Ankle
___Foot
___Toes
___Internal

*Please indicate ___ Left ___Right

*Have you injured this part of the body before ___YES ___NO
if yes give details

Type of Injury

___Puncture
___Foreign Body
___Sprain/Strain
___Hernia
___Fracture/Dislocation
___Infectious Disease
___Burn/Scold
___Irritations/Dermatitis

Cause

___Fall from equipment
___Fall on same level
___Fall from different level
___Fall from fainting
___Slip on something
___Spill-Spray
___Slip, no fall
___Struck by person
___Pulling
___Pushing
___Lifting
___Reaching or Bending
___Exposure
___Overexertion
___Heart Attack
___Other _____

MEDICAL TREATMENT - Date of treatment & Name of Physician and/or Hospital

___No Treatment
___Minor Treatment By Employer _____
___Treatment by Physician _____
___Emergency Care-Rescue and/or Hospital _____
___Hospitalized more than 24 hours _____
___Major Medical _____

Supervisor Comments:

Supervisor Signature _____ Date: _____

Employee Signature _____ Date: _____

Sevier County Workers Compensation Accident Form

WITNESS WRITTEN STATEMENT

Witness Name: _____ Phone: _____

Witness Address: _____

Injured Workers Name: _____

Date of Accident: _____

Witness Comments:

Witness Signature: _____ Date: _____