Cortland County Community Action Program, Inc.

Accident Report

Employee Name Please Print **Shift: beginning/end time** **Department Name**

Reported Accident to **Supervisor Signature**

Accident

Address Where Accident Occurred:

Time of Accident: ____ AM ____PM	**Date of Accident:**	**Date Stopped Work because of this Injury/Illness**

Name(s) of Witness(es):

Nature of Injury

Nature of Injury and Part(s) of Body Affected:

Did you go to the Doctor or Hospital? **Yes** **No**

Name and Address of Doctor who treated you:

Name and Address of Hospital

Cause of Injury

What were you doing when Injured? (Please be specific. Identify tools, equipment or materials that you were using).

How did the Accident or Exposure Occur? (Please describe fully the events that results in injury or occupational disease. Tell what happened and how it happened)

Object or substance that directly injured employee: e.g the machine struck against or which struck him/her, the tool broke, the chemical irritated his/her skin, the thing(s) he/she was lifting, pulling, etc.)

Date of this Report: _____

Employee Signature

Revised: 5-07-2012