

ACCIDENT REPORT FORM

Name of Injured: _____ SS # _____

Street Address: _____

City: _____ State: _____ Zip: _____

Local 16 Job #: _____ Job Name: _____

Job Date(s): _____ Venue: _____

Steward: _____ Phone: _____

Employer: _____

Employer Representative: _____ Phone: _____

Payroll Company (if different): _____

Work Comp Insurance Carrier: _____

Policy Number: _____

Date of Injury: _____ Time of accident: _____

Address and description of where accident happened:

Part(s) of body affected: _____

Details of the accident

(Describe fully what happened and how it happened. Use reverse if need more space):

Accident Report Form

List all others involved in this accident:

Name: _____
Address: _____
Phone: _____
Relationship: _____

Witnesses to this accident:

Name: _____
Address: _____
Phone: _____
Relationship: _____

TREATMENT INFORMATION, if available:

Name of Treating Physician: _____
Address of Treating Physician: _____
Phone: _____

Name of Treating Hospital: _____

Address of Treating Hospital: _____
Phone: _____

Follow-up Information, if available:

Disabling Injury? Yes [] No []
Employee Returned to Work? Yes [] No []
Date Returned to Work: _____

This form is for the employer and union staff only. It is not designed to replace actual insurance forms. Please fill out the appropriate employer's insurance forms as soon as possible.
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