DINING SERVICES ACCIDENT REPORT
(Bodily)

Full Name of Injured: _____ DOB: _____ A# _____

Phone: _____ Address: _____

Marital Status: Married ◯ Single/ Divorced ◯ Seperated ◯

Occupation/ Job Title: _____ _____ Date of Hire:_____

Date of Injury: _____ Time Began Work: _____ Time of Injury: _____

Injury/ Illness/ Exposure Occur on Employer's Premises? YES ◯ NO ◯

Department or Location Where Injury/ Illness/ Exposure Occured: _____

Type of Injury/ Illness/ Exposure: _____

List Specific Part(s) of Body Affected: _____

List All Equipment, Materials, Chemicals Employee Was Using When Injury Occured: _____

_____

Work Process Performed Prior to Injury: _____

How Did Injury Occur? (describe sequence of events & objects/ substances used) _____

_____

_____

Were Safeguards Provided? YES ◯ NO ◯ Were They Used? YES ◯ NO ◯

Did Employee Get Treatment From A Doctor/ Hopital? YES ◯ NO ◯

If answer is Yes, please name Provider and Address: _____

Did Employee Return to Work? YES ◯ NO ◯ Date/ Time: _____

Witness(es) Name(s): _____

Supervisor's Signature: _____ Date: _____