Employee Notification of Workplace Accident

To be completed immediately after a workplace accident for workers' compensation benefits

Employee Information

To be completed by the employee.

Last Name: ________________________ First Name: ________________________ ID: ______________

Best phone number to reach you: ____________________

Did you tell your supervisor of the injury/illness? Yes ☐ No ☐ If so, when? ____________

Department: ______________________ Job Title: ______________________

Name of Supervisor: ____

Supervisor Contact Phone No. (if known): ______________________________

Employee Affiliation/Type:
- ☐ Administrative
- ☐ Buildings & Grounds
- ☐ Highway
- ☐ Seasonal: Marina
- ☐ Seasonal: Pool
- ☐ Seasonal: Other
- ☐ Volunteer

Accident Information

Please answer all questions

Date of injury/illness *(mm/dd/yyyy)*: __________ Time you started work: __________ AM ☐ PM ☐ Time of injury/illness: ________ AM ☐ PM ☐

Location (building name, room, etc.) where injury/illness occurred: ______________________________

How did the incident occur / what task were you engaged in at the time injury/illness began? ______________________

Type of Injury

Please Select:
- ☐ Bite/ Scratch
- ☐ Bodily Reaction
- ☐ Caught in/ Under/ BTN
- ☐ Contact w/ Chemical
- ☐ Contact w/ Electrical
- ☐ Extreme Temperature
- ☐ Fall from Elevation
- ☐ Fall on the Same Level
- ☐ Motor Vehicle
- ☐ Needle Stick
- ☐ Overexertion
- ☐ Puncture
- ☐ Rubbed/ Abraded
- ☐ Slip/Trip
- ☐ Struck Against
- ☐ Struck By
- ☐ Other (describe below)
- ☐ Exposure

If Exposure, Select Type:
- ☐ Dermal (Skin)
- ☐ Injection
- ☐ Inhalation
- ☐ Ingestion

If other, please describe:

____

If the accident was caused by a needle, please list the type of needle (device brand/type):

____

Nature of Injury

Please Select:
- ☐ Abrasion
- ☐ Animal Bite or Scratch
- ☐ Burn
- ☐ Chemical Spill
- ☐ Chemical Exposure
- ☐ Contusion
- ☐ Crushed
- ☐ Foreign Body
- ☐ Fracture
- ☐ Illness/ Infection
- ☐ Laceration
- ☐ Needle Stick
- ☐ Puncture
- ☐ Rash
- ☐ Repetitive Motion
- ☐ Sprain/ Strain
- ☐ Struck By/ Against
- ☐ Other (specify below)

Car Accident? Yes ☐ No ☐

Description (if not above):

____

____

____

Body Part

Please Select:
- ☐ Abdomen
- ☐ Ankle
- ☐ Elbow
- ☐ Disc (Back)
- ☐ Fingers
- ☐ Foot
- ☐ Groin
- ☐ Head
- ☐ Knee
- ☐ Lower Back
- ☐ Multiple Body Parts
- ☐ Neck Injury
- ☐ No Physical Injury
- ☐ Pelvis

Right Side ☐ **Left Side** ☐

Description (if not above):

____

____

____

If you need help filling out this form, please ask your supervisor or human resources

Were you seen in an emergency room? Yes ☐ No ☐

Were you hospitalized overnight as an inpatient? Yes ☐ No ☐

Were you in contact with blood or bodily fluids? Yes ☐ No ☐

What object directly harmed you? ______________________

Were you harmed by a sharp object? Yes ☐ No ☐

To whom did you report the accident? (Name): ____

Date reported (mm/dd/yyyy):__________Time reported: ________________

Witness name (if known): ____

Witness' email: _________________________________

Witness' phone: ________________________________

Signature

I CERTIFY THAT THE ACCIDENT INFORMATION PROVIDED ABOVE IS TRUE.

Completed by Employee ☐ **Completed by Employer** ☐

If completed by employer, state your name and relationship to the employee:____

Signature:____ **Date** ***(mm/dd/yyyy):*** _________________________________

Submitting Your Accident Report

This form is only complete after it has been submitted to either your HR Departmental contact or your supervisor.

Please submit this form by scanning and sending it to support@townofclayton.com.

Received by HR:

Date: ________________ Initials: _______________

Injured Worker Packet to Employee: ☐

Forward to Report and C-2F to NCA Comp: ☐