

Accident Report

211 Tenth Street
Wakefield NE 68784
Phone: 402-287-2061 Fax: 402-287-2065



Injured Party: _____ SSN: _____

Address: _____

Sex: Male Female Marital Status: M S W D DOB: _____

Date of Injury: ____/____/____ Time of Injury: _____ A.M./P.M.

Date Reported to Employer: ____/____/____ Time Reported to Employer: _____ A.M./P.M.

Job Title: _____ Dept.: _____ How Long in Dept.: _____

Hours Worked Per Day: _____ Hours Per Week: _____ Days Per Week: _____

Date of Hire: ____/____/____ Employment Status: Full-Time Part-Time

Accident Location (i.e. building, room, etc.): _____

Object that injured employee: _____

What was employee doing when injury occurred? _____

How did accident/injury occur? _____

Describe injury in detail and part of body affected: _____

Individual(s) who witnessed accident: _____

Time work day/shift began: _____ A.M./P.M.

Has injured employee returned to work? YES NO

Did employee receive Medical Authorization form? YES NO

Was First Aid Provided? YES NO

If YES, by whom? _____

What First Aid treatment was given? _____

Date/Time this report was completed: ____/____/____ _____ A.M./P.M.

Employee Signature

Supervisor Signature

Submit completed copy to ESU #1 Central Office