WEST BEND®

General / OSHA

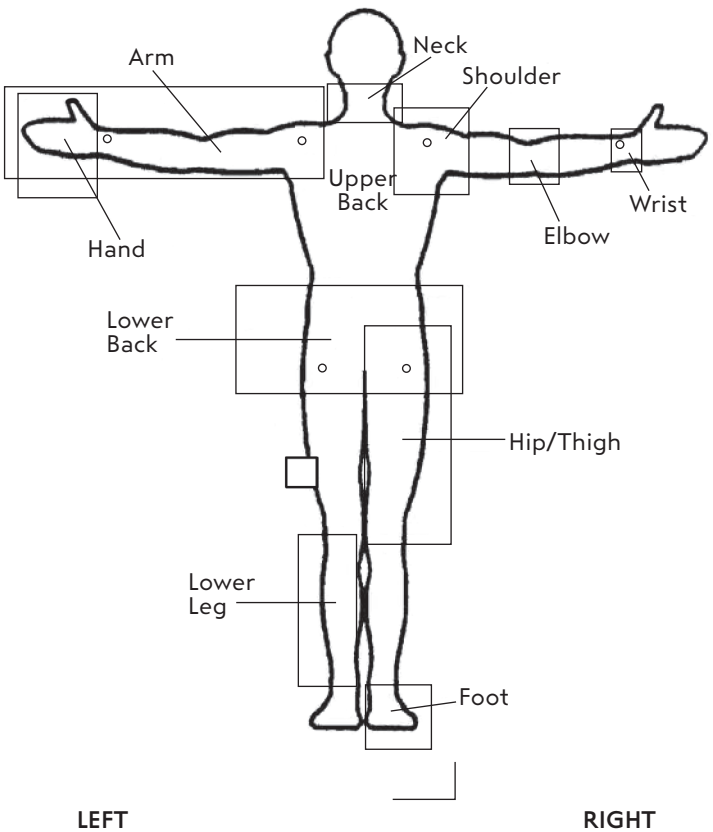
Employee Accident Report

Name: _____ Accident Location: _____

Date of Injury: _____ Time _____ am ☐ pm ☐ Date Reported: _____

Witnesses: _____

Accident Description:

Injured Area	Indicate Area of Injury	Type of Injury
1 ☐ Head 2 ☐ Eye: ☐ L ☐ R 3 ☐ Shoulder: ☐ L ☐ R 4 ☐ Arm: ☐ L ☐ R 5 ☐ Elbow: ☐ L ☐ R 6 ☐ Wrist: ☐ L ☐ R 7 ☐ Hand: ☐ L ☐ R 8 ☐ Finger – Specify: 9 ☐ Back 10 ☐ Chest 11 ☐ Abdomen 12 ☐ Pelvis 13 ☐ Hip: ☐ L ☐ R 14 ☐ Leg: ☐ L ☐ R 15 ☐ Knee: ☐ L ☐ R 16 ☐ Ankle: ☐ L ☐ R 17 ☐ Foot: ☐ L ☐ R 18 ☐ Toe – Specify: 19 ☐ Other:		1 ☐ Abrasion 2 ☐ Amputation 3 ☐ Bite: 4 ☐ Bruise 5 ☐ Burn 6 ☐ Concussion 7 ☐ Cut / Laceration 8 ☐ Foreign Body 9 ☐ Fracture 10 ☐ Hearing Impaired 11 ☐ Infection 12 ☐ Pain: 13 ☐ Puncture 14 ☐ Rash / Derm. 15 ☐ Respiratory 16 ☐ Strain / Sprain 17 ☐ Other:

Employee Accident Report

Have you ever injured this body part before? ☐ Yes ☐ No If so, when? _____

Are you currently receiving medical treatment for the prior injury? ☐ Yes ☐ No

What do you believe caused this accident?

What can be done to prevent this from happening in the future?

Signature: _____ Date: _____