FLORIDA TECH

EMPLOYEE ACCIDENT/INJURY REPORT

Injury/illness that occurred _____ Part of body affected _____

Cause of injury _____

Paid for date of injury R Yes R No Last date employee worked _____

Return to work? R Yes R No If yes, give date _____ Date of death (if applicable) _____

MEDICAL INFORMATION

Employee received medical care at time of injury? R Yes R No Treated by a physician? R Yes R No

Physician/hospital name _____ Phone _____

Address _____ City _____ State _____ ZIP _____

List of activity prior to accident (work-related activity only):

Has this part of your body been injured before? R Yes R No If yes, when _____

Employee signature _____ Date _____

Work # _____

R Full time R Part time Salary/hourly wage _____ Date of hire _____

ACCIDENT INFORMATION

Date of accident _____ Time of accident _____ R AM R PM Date first reported _____

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