



County of Orangeburg Accident and Injury Report

ALL THREE PAGES OF THIS REPORT FORM MUST BE COMPLETED BY **THE SUPERVISOR, DEPARTMENT HEAD, OR DEPARTMENT RISK MANAGER** AND FOWARDED TO HUMAN RESOURCES WITHIN 24 HOURS. ALL INJURIES MUST BE REPORTED.

Date of injury: (mm/dd/yyyy)		Employee Name:		11/5/2013
SSN#		Home Address:		
City		State	Zip Code	
Home Phone# (803-555-5555)		Work Phone# (803-555-5555)		
Date of Birth (mm/dd/yyyy)		Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Rate of pay (hourly):		
Date of employment:(mm/dd/yyyy)		Department:		
Job Title:		Time Employee Started Work-Day of Accident:		
Time of injury: (HH:MM am/pm)		Last Work Date(mm/dd/yyyy):		
		# Days Worked per Week:		
Location of accident :				
Was accident on Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Witness:		Phone# (803-555-5555):		
Check the box that best describe the type of injury incurred:				
<input type="checkbox"/> Amputation	<input type="checkbox"/> Poisoning, specify			
<input type="checkbox"/> Contusion, bruises	<input type="checkbox"/> Sprain, strain, dislocation			
<input type="checkbox"/> Burn (heat, chemical)	<input type="checkbox"/> Electrical Shock			
<input type="checkbox"/> Concussion or Paralysis	<input type="checkbox"/> Foreign body, specify			
<input type="checkbox"/> Dermatitis (skin rash)	<input type="checkbox"/> Fractured			
<input type="checkbox"/> Cut (laceration, abrasion	<input type="checkbox"/> Exposure only, specify			
Other, Specify _____				
Additional information regarding type of injury: _____				



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Other Medical Information:	
<input type="checkbox"/> Fatality Date: (mm/dd/yyyy)	<input type="checkbox"/> Medical Attention Date: (mm/dd/yyyy)
<input type="checkbox"/> Physician	Hospital
<input type="checkbox"/> First Aid,specify	



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TO BE COMPLETED BY THE SUPERVISOR, DEPARTMENT HEAD, OR DEPARTMENT
RISK MANAGER

Do you anticipate this employee losing time from work due to this injury? Yes No (Do not include the day of the accident)

Do you anticipate this employee incurring temporary disability (unable perform regular duties from this injury)?
 Yes No

Does this employee work a shift? Yes No

If yes, what is the date of his/her next schedule workday? (mm/dd/yyyy)

What acts, failure to act, and/or conditions contributed most directly to this accident?	
What safety equipment is provided to the employee that could have prevented or lessened this accident?	
Was the employee using this safety equipment at the time of this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What action has or will be taken to prevent reoccurrence?	

Supervisor	Date(mm/dd/yyyy)	Dept. Head	Date(mm/dd/yyyy)
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BODY PART CHART

Employee Name:			
Date of Accident:	(mm/dd/yyyy)	Date of Report:	(mm/dd/yyyy)
Employee Signature:			
Reported By:			

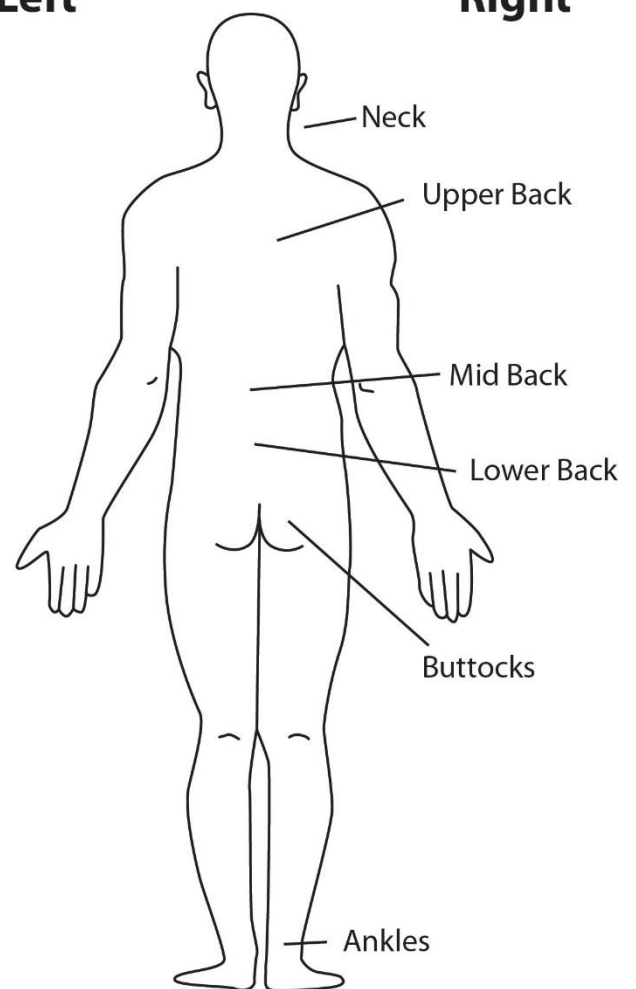
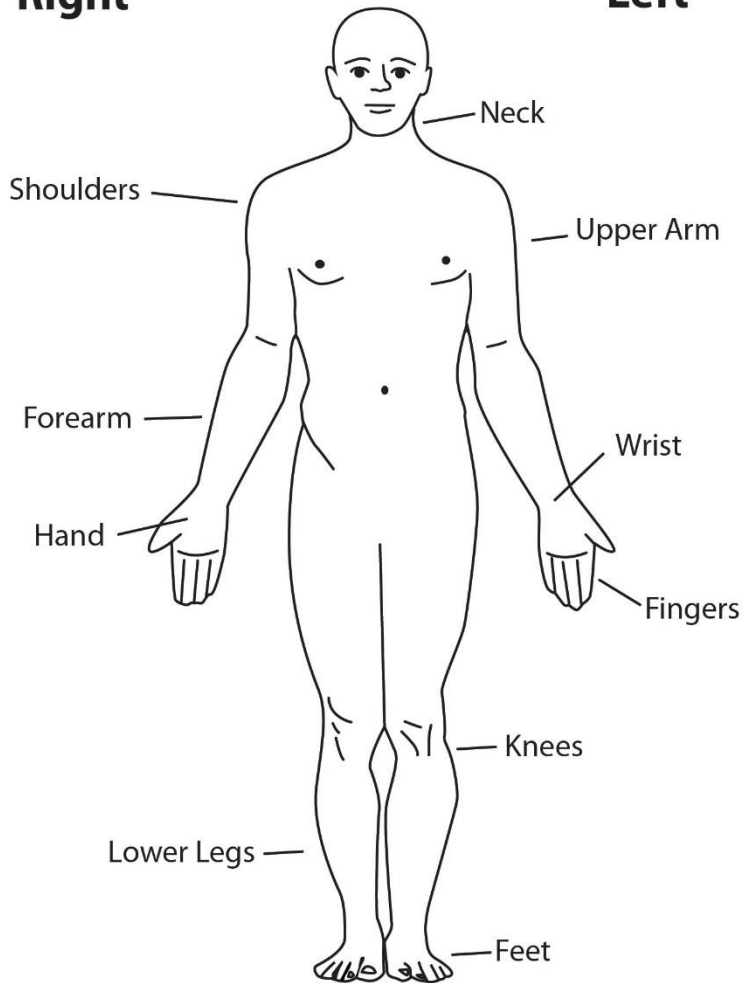
Instructions: Please mark the injured body part and have the employee initial beside the part.

Right

Left

Left

Right



Front

Back