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) 11/5/2013	Employee Name:
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: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ 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? ☐ Yes ☐ No	
Witness:	Phone# (803-555-5555):

Check the box that best describe the type of injury incurred:

☐ Amputation	☐ Poisoning, specify
☐ Contusion, bruises	☐ Sprain, strain, dislocation
☐ Burn (heat, chemical)	☐ Electrical Shock
☐ Concussion or Paralysis	☐ Foreign body, specify
☐ Dermatitis (skin rash)	☐ Fractured
☐ Cut (laceration, abrasion	☐ Exposure only, specify

Other, Specify _____

Additional information regarding type of injury: _____

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Other Medical Information:	
☐ Fatality Date: (mm/dd/yyyy)	☐ Medical Attention Date: (mm/dd/yyyy)
☐ Physician	Hospital
☐ First Aid,specify	

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Check the box that best describes the Area of Injury:			
☐ Head	☐ Eye, ☐L ☐R	☐ Ear, ☐L ☐R	☐ Mouth, Teeth
☐ Facial	☐Neck	☐ Shoulder, ☐L☐R	
☐ Arm, Elbow, ☐L ☐R			
☐ Hand/Wrist, ☐L ☐R		☐ Finger, ☐L ☐R	
☐ Hip, ☐L ☐R			
☐ Uro/Genital		☐ Leg/ Knee ☐L ☐R	
☐ Ankle/Foot ☐L☐R			
☐ Toe ☐L☐R		☐ Chest (including ribs, internal organs)	
☐ Back, Spine		☐ Abdomen (including internal organs)	
☐ Multiple parts (such as arm), Specify:			
☐ Other, Specify:			
Additional information Regarding Area of Injury:			

Describe clearly and briefly how the accident occurred:
Employee Signature: **Date:**

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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? ☐ Yes ☐ 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.