Employee Accident Report

Employee Name:	Date of Birth:
Last First Middle	/ /

Home Address	SSN: — —

City	State, Zip Code	Phone #

ACCIDENT INFORMAITON

Time shift began: Time shift was to end:	Date of accident: Time of accident: Time accident reported to supervisor:	
Venue: Area of accident:	Will you be missing the remaining days on the call?	Will you be missing / declining future calls?
Describe how the accident occurred: (Please be as specific as possible)		
Describe bodily injury sustained: (Please be as specific as possible)		
Did you receive first aid on site?	What first aid treatment did you receive?	Who administered treatment?
Recommendation on how to prevent this injury from recurring:		

Have you previously filed a work comp claim?	Body part affected:	Date of claim:
Name of Supervisor:		
Name of Witness:		
Employee signature:		Date:

ONCE FORM IS COMPLETED FAX TO: (801)328-1307 or E-MAIL: julie@utpgroup.com