**Instructions**: Employees shall use this form to report all work related injuries, illnesses, or “near miss” events (which could have caused an injury or illness) – *no matter how minor.* This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by the employee as soon as possible and given to a supervisor to forward to UTP for review.

**Employee Accident Report**

|  |  |
| --- | --- |
| Employee Name: | Date of Birth: |

Last First Middle

|  |  |  |  |
| --- | --- | --- | --- |
| Home Address | | | SSN: |
| City | State, Zip Code | Phone # | |

**ACCIDENT INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Time shift began:  Time shift was to end: | | | Date of accident: Time of accident:  Time accident reported to supervisor: | |
| Venue:  Area of accident (ie dock, stage): | 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 (not including today)? | Body part affected: | Date of claim: |
| Name of Supervisor: | | |
| Name of any witnesses to today’s incident: | | |
| Employee signature: Date: | | |

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