BROWN COUNTY EDUCATIONAL SERVICE CENTER

EMPLOYEE INCIDENT/ACCIDENT REPORT

To Be Completed by Injured Employee * OSHA 301 Info in BOLD

Return to Supervisor ASAP

Name: _____ Social Sec. No. XXX-XX- _____ (Last 4-digits only)

Home Address: _____ **Date of Birth:** _____ **Sex:** ☐ Male ☐ Female

City/State/Zip: _____ Telephone: ( ) _____

Title/Position: _____ Department: _____

Accident Location: _____

Date of Injury or onset of symptoms: _____ Time: _____ ☐ am ☐ pm

Described what caused the injury/symptoms, what you were doing just before the incident, and what you did after the incident (if you need more space, write on the back of this form). Be specific-name any objects or substances involved:

Were you performing regular duties at the time of accident? ☐ Yes ☐ No

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who? _____

Did you report this incident to anyone? ☐ Yes ☐ No If no, why not? _____

If yes, to whom did you report it?:_____ Title/Position:_____ When: _____

What time did you start work today? _____ am/pm. **What time was the injury?**_____am/pm ☐ Unknown

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger**):**

_____

_____

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull): _____

_____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe: _____

_____

Provided by: _____

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?: _____

Where?: _____ If treatment was not sought immediately, explain why?: _____

_____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury?: _____ By whom or where?:_____

Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury: _____

Medical Release **– Under current Workers' Compensation Law, the employer is entitled to a signed medical release.** I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print): _____ **Employee Signature:** _____

Date (required): _____