

## **Employee Accident Report**

Employee Name:					Date of Birth:	
					/	/
Last	First	Middle			/	
					-	
Home Address						
				SSN:		
City	State, Zip Code	Phone #				
			<u> </u>			
ACCIDENT INFORMAITON						
Time shift began:		Date of accident:	Time of accident:			
Time shift was to end:  Time accident reported to supervisor:						
				Will you be missing / declining future calls?		
Area of accident:  Describe how the accident occurred: (Please b	e as specific as possible)				***************************************	-
bestine now are desident dead in the see 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:						
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Have you previously filed a work comp claim?	Body part affected:	Date of claim:				
, ,						
Name of Supervisor:						
Name of Supervisor.						
Name of Witness:						
Employee signature:			Date:			

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