CONTRACTOR ACCIDENT REPORT

EMPLOYEE NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

PHONE:_____ **SEX:** **M** **F**
(CIRCLE ONE)

NAME OF COMPANY: _____

ADDRESS: _____

SUPERVISOR: _____

DATE & TIME OF ACCIDENT:_____

DATE & TIME FIRST REPORTED: _____

LOCATION OF ACCIDENT: _____

DESCRIPTION OF INJURIES_____

_____

MEDICAL SERVICES REQUIRED:_____**YES**_____**NO**

NAME OF DOCTOR OR HOSPITAL:_____

ACCIDENT DETAILS (CONDITIONS, MACHINERY, EQUIPMENT, MATERIALS, WEATHER, OTHER PERSONNEL INVOLVED) _____

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_____

WITNESSES _____

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