

EMPLOYEE INCIDENT STATEMENT

EMPLOYER: EAST MISSOURI ACTION AGENCY		EMPLOYER POLICY #: 1015078	
EMPLOYER CONTACT NAME: TERI SCHWEISS		EMPLOYER PHONE #: 573-431-5191 x 1108	
NAME OF INJURED EMPLOYEE (<i>LAST, FIRST, MIDDLE INITIAL</i>)			
ADDRESS (<i>STREET, CITY, STATE, ZIP</i>)			
PHONE #	DATE OF BIRTH	SOCIAL SECURITY #:	SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
DATE OF HIRE	PROGRAM	SUPERVISOR	
JOB TITLE		JOB PERFORMED	
DATE OF INCIDENT	TIME OF INCIDENT <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE REPORTED	INCIDENT LOCATION
RATE PER HOUR	DAYS WORKED PER WEEK	HOURS WORKED/DAY	TIME BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM
EXTENT OF INJURY <input type="checkbox"/> NO INJURY <input type="checkbox"/> FIRST AID ONLY <input type="checkbox"/> TAKEN TO CLINIC <input type="checkbox"/> TAKEN TO ER <input type="checkbox"/> FATALITY			
TREATING MEDICAL FACILITY/DOCTOR (<i>Name & Address</i>)			
BODY PART INJURED (<i>Lt ring finger, Rt ankle, etc</i>)			
NATURE OF INJURY (<i>Scratch, Cut, Bruise, etc</i>)			
WHERE AND HOW DID ACCIDENT HAPPEN?			
WHAT WAS EMPLOYEE DOING AT TIME OF ACCIDENT?			
LIST ALL EQUIPMENT, MATERIALS, OR CHEMICALS USING WHEN INCIDENT OCCURRED			
ANY OTHER WITNESSES? <input type="checkbox"/> YES <input type="checkbox"/> NO		WERE THERE OTHERS INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME:	PHONE:	NAME:	
NAME:	PHONE:	NAME:	

WAIVER: I DO NOT WISH TO SEEK MEDICAL TREATMENT AT THIS TIME	
SIGNATURE:	DATE:

REPORT COMPLETED BY:	
SIGNATURE:	DATE:
TITLE:	PHONE #:

MAIL or FAX COMPLETED FORM TO: TERI SCHWEISS PO BOX 308 PARK HILLS, MO 63601 FAX: 573-431-6773