Workplace Accident Report Form

Organization Information

Organization Name

Location / Department

Employee Information

Employee Name

Employee ID

Job Title

Supervisor Name

Accident Details

Date of Accident

Time of Accident

Accident Location

Describe What Happened

Nature of Injury (if any)

Names of Witnesses (if any)

First Aid or Medical Attention Provided

Other Information

Reported To (Name & Title)

Date of Report

Additional Comments