Core Values Driven
An Owl Company
Career Systems Development Corp

Employee Accident/Injury Report

Instructions:

1. Please print clearly and legibly.
2. Please turn in ***completed form*** to Human Resources or the Safety Officer within 24 hours of accident.

Section A: Personal Information

Employee Full Name: _____ Date: _____

Job Title: _____ Dept.: _____

Street Address: _____ Area Code Phone #: _____

City & Zip Code: _____ Date of Hire: _____

_____ Date of Birth: _____

Section B: Description of Accident/Injury

Date of Accident _____ Time of Accident: _____

Where the accident occurred? _____ Any witnesses? ☐ Yes ☐ No

If witnesses, who _____

Were you working when the accident/incident happened? ☐ Yes ☐ No

What were you doing when the accident/incident occurred? Be specific, with a student/using tools/equip.

How did the accident/incident happen? Be specific use back page if necessary.

Was there any object, person or substance that directly caused this accident/incident? ☐ Yes ☐ No
If yes, please describe.

Describe the injury or illness (Cut, bruise, sprain. Be specific.)

What type of assistance or first aid was administered? ☐ None
☐ Medical Dept

Was the accident/incident limited to first aid? ☐ Yes ☐ No

If no, you need to see the Safety Officer or Human Resources Immediately.
If Yes, sign waiver form on back.

***Note**: Workers' Compensation fraud laws make it a felony for anyone to file a false or fraudulent statement or to submit a false report or any other document for the purpose of obtaining workers' compensation benefits. Anyone caught performing these illegal acts will be prosecuted. If convicted, the person can face up to 5 years in prison and/or up to a $50,000 fine.*

State Fund # 15765

Signature _____ Date _____

Medical Refusal Form

I, _____ Have been offered medical treatment
(EMPLOYEE NAME)

by CSD on _____ at the company provided clinic.
(DATE)

The treatment was offered to me because of an occupational injury/illness. .

I have refused the medical treatment offered on _____
(Date)

I understand that if I want medical treatment in the future that I am fully entitled to such treatment, and may request it from the Company.

Reason for Refusal of Medical Treatment: _____

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____