

EMPLOYEE ACCIDENT REPORT

CONSUMER/EMPLOYER		ADDRESS	
CITY	STATE	ZIP	PHONE
FIRST NAME (INJURED EMPLOYEE)		LAST NAME	
STREET ADDRESS		CITY	STATE ZIP
HOME PHONE #		SOCIAL SECURITY #	
DATE OF BIRTH		SEX M / F	
DATE OF ACCIDENT	TIME	A.M. / P.M	TREATMENT YES / NO

Specifics on how accident occurred:

Describe Injury:

Employee statement:

Signatures:

Employee: _____ Date: _____

Consumer/Employer _____ Date: _____

Witness:(names)

Referred for treatment to panel doctor _____ or emergency room _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Has employee missed time from work? Yes ___ No ___

**ACKNOWLEDGEMENT OF EXPLANATION OF RIGHT AND DUTIES OF THE PENNSYLVANIA WORKER'S
COMPENSATION ACT**

Employee signature: _____ Date: _____