

**EMPLOYEE ACCIDENT REPORT  
TO BE COMPLETED BY INJURED EMPLOYEE**

Injured Employee Name: \_\_\_\_\_ Date of Injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Owner/Operator Name: \_\_\_\_\_ City of Injury: \_\_\_\_\_ Store No: \_\_\_\_\_

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1. Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Tel. No. ( ) - \_\_\_\_\_

2. S.S. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Job Title: \_\_\_\_\_

3. Department where injured: \_\_\_\_\_ Day of Week \_\_\_\_\_ Time \_\_\_\_\_

4. Describe details of accident (how, what, where, why): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Nature, extent, degree and body location of injury \_\_\_\_\_

\_\_\_\_\_

6. Were there any eyewitnesses to the accident? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, give their names \_\_\_\_\_

I, \_\_\_\_\_, (employee), the undersigned herewith certify that the above is a true and correct statement of fact, and that I made such statement of my own free will. I understand that my Employer does not carry Workers' Compensation insurance, and furthermore, that any payments to me or anyone else for expenses in connection with my accident and resulting injury is not an admission of liability on the part of my Employer. I also authorize a designated representative of my Employer to accompany me to any healthcare provider when receiving medical treatment or services for an occupational injury that occurred during my employment with my Employer. I further acknowledge that I may be required to submit to a drug/alcohol screening for any occupational injury that requires medical treatment, and release my Employer from all liability relating to such testing or the release of test results.

X: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
EMPLOYEE SIGNATURE DATE

X: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
WITNESS SIGNATURE DATE

\_\_\_\_\_  
WITNESS NAME PRINTED

X: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
TRANSLATOR SIGNATURE (If applicable) DATE

\_\_\_\_\_  
TRANSLATOR NAME PRINTED

**Submit this report to your restaurant owner operator promptly & fax to  
Sedgwick, Attn: Chuck Eastwood. Fax # 210-332-1590**