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