Instructions: Employees shall use this form to report all work related injuries, illnesses, or "near miss" events (which could have caused an injury or illness) – ***no matter how minor***. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by the employee as soon as possible.

Employee Accident Report

Employee Name:	Date of Birth:
Last First Middle	/ /

Home Address	SSN: — —

City	State, Zip Code	Phone #

ACCIDENT INFORMATION

Time shift began: Time shift was to end:	Date of accident: Time of accident: Date and time accident reported to supervisor:	
Venue: Area of accident (ie dock, stage):	Will you be missing the remaining days on the call? Yes No	Will you be missing/declining future calls?
Describe how the accident occurred: (Please be as specific as possible)		
Describe bodily injury sustained: (Please be as specific as possible)		

Did you receive first aid on site?	Do you need further medical attention?	If further medical attention is needed beyond first aid please contact our office at: 801-328-1298
Have you previously filed a work comp claim (not including today)?	Body part affected on previous claim:	Year of previous claim: 01/24/2020

Name of Supervisor:	Supervisors Phone #:	Union #:
Name of any witnesses to today's incident:		
Your email address:		

Employee signature: _____

Date: 01/24/2020

ONCE FORM IS COMPLETED: FAX TO: (801)328-1307 or E-MAIL: workcomp@utpgroup.com, if you are filling it out online it will be emailed to me directly.