LOCATION : _____

Phone ( )
Fax ( )

EMPLOYEE ACCIDENT REPORT

*******Please complete this form in your own handwriting and return to your employer immediately.***********

EMPLOYEE INFORMATION

Employee Name: (First, Middle, Last)	Social Security No.: __ __ __ - __ __ - __ __ __ __	Date of Birth: Month: ____ Day _____ Year _____

Street Address:	City:	State:	Zip:

Male Female	Marital Status:	Telephone: ( )
		Email:

Position:	Date of Hire:	Supervisor's Name:

ACCIDENT INFORMATION

Date of Accident:	Time of Accident: ___:___ AM☐PM☐	Date Reported:	Reported to Whom?:
Did you require medical treatment? Yes ☐ No ☐		Date of First Treatment:	Type of Injury:

Name of Physician/Hospital Providing Medical Treatment:	Phone No:

What were you doing when you were injured?

Describe how the accident happened:

Where specifically did the accident occur?:

Describe the part(s) of your body injured:

Did anyone witness the accident? Yes ☐ No ☐	Please list names of Witnesses:
Have you ever been treated for similar injury? Yes ☐ No ☐ If yes, when:	Describe previous treatment:

Previous Treatment Medical Provider Name and Address:

I hereby authorize any physician, hospital, pharmacy, or medically related facility, insurance company, employer or other person or other organization, institution or person, that has any records or knowledge of me to disclose, whenever requested to do so by my employer or Providence Risk & Insurance Services, Inc. or it's representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

By my signature, I hereby acknowledge that I know it is a crime to complete this form with information I know is false or to omit any facts that might be pertinent to this claim. I certify that the above information is correct and that I have completed this form truthfully without any coercion from my employer.

I agree that should this Injury or Illness result from the actions of a third party, that unless otherwise stipulated by the Plan, I will repay to the Plan all amounts paid by the Plan in connection with this Injury or Illness upon recovery of any amounts.

Dated _____ Signature: _____
(Employee or Legal Guardian)

 - Fax this form to: (210) 494-7694 or mail to: P.O. Box 700370, San Antonio, TX 78270