

LSJE, LLC

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Phone: [REDACTED] E-mail: [REDACTED]

Accident Report Form

Today's Date: Date of Incident:

Employee Name: Title/Position:

Location of Incident:

Witnesses:

Was employee wearing recommended safety devices and exercising proper operation procedures? Yes No

Comments:

Employee (select one): Accepted Medical Treatment Declined Medical Treatment

Doctor and/or Hospital Visited:

Date(s) of Visit:

Date(s) of Follow-up Medical Treatment (if applicable):

Has employee provided a doctor's written permission to return to work? Yes No

If no, when is employee able to return to work?

Employee Signature: Date:

Supervisor Signature: Date: