

TOWN OF RIVERHEAD EMPLOYEE ACCIDENT REPORT

PLEASE COMPLETE AND SUBMIT TO THE ACCOUNTING DEPARTMENT

Name of injured employee: _____ SS#: _____

Home address of employee: _____ Age: _____

Job Title: _____ Department: _____ Date of Report ___/___/___

Where did accident occur? _____

Name of Witnesses: _____

Time of accident: _____ a.m./p.m. Date of accident: ___/___/___

Date stopped work due to this injury: ___/___/___ Date returned ___/___/___

Nature of injury and part(s) of body affected: _____

Name and address of doctor or hospital: _____

How did employee allegedly get injured? _____

Was employee wearing safety equipment? _____ Yes _____ No

If yes what equipment was employee wearing? _____

Immediate Supervisor signature _____ Date signed ___/___/___

Department Head signature _____ Date signed ___/___/___

Employee signature: _____ Date signed ___/___/___

Employee comments: _____

YOU ARE REQUIRED TO NOTIFY THE ACCOUNTING DEPARTMENT THE *FIRST* DAY YOU RETURN TO WORK FROM YOUR WORKER'S COMPENSATION INJURY

Should this claim be controverted? _____ YES _____ NO

If yes give reason why _____

Signature of person recommending claim to be controverted _____