COOK COUNTY BOARD OF COMMISSIONERS

ACCIDENT / INJURY REPORT

Employee: ____
Employee Social Security #: ____________________________
Address of Employee: _________________________________
____

Home Phone Number of Employee: _____________________

Date of Birth: ____

Employee's Job Title: _________________________________

Date of Accident: ___________________ Time of Accident: ________________

Exact location that injury/accident occurred: ______________________________

____

Describe what employee was doing at the time injury/accident occurred: _________

____

____

If there were any witnesses, please list name: _______________________________

____

What Body part was affected by injury? _________________________________

Did employee complete work day on the date of the accident? Yes ___ No ____

Did employee file for leave time on the date of accident? Yes ___ No ____

Date of the first work day employee missed due to accident? __________________

Did employee seek immediate medical attention? Yes ____ No _____

If yes, please give name of Doctor or Medical Facility: _______________________

____

Volunteer Firefighters Please Provide Additional Information:

Name of Employer: ____

Date of Hire: ____

Hourly rate of Pay: ____