ON THE JOB - ACCIDENT REPORT

Must be completed in FULL

Employer:
Ampa Events
6701 Janway Rd
Henrico, VA 23228

Signature of Employee:_____ _____
Date

Signature of Supervisor:_____ _____
Date

Time and Place of Injury:

Location where accident occurred:	Date of Injury:	Hour of injury: _____AM PM

Injured Worker:

Name of Injured Worker:	Phone Number:	Social Security Number:
Injured Worker's Mailing Address:		Occupation at time of Injury:
Date of Birth:	Sex:	

Nature and Cause of Accident:

Machine, tool, or object causing injury or illness:
Describe fully how injury or illness occurred:
Describe nature of injury, occupational disease, or illness, including body parts affected:

Medical Treatment :

Minor Medical treatment by EMP:	Hospitalization for more than 24 hrs.:	Name of approved Medical Facility:

Medical Treatment Refusal:

I was offered and declined medical treatment: _____
Date