# Preliminary Accident Report

This is not a First Report of Injury form.
Use this information as a basis for filing the First Report of Injury.

| | | |
|---|---|---|
| Employee's Name | | |
| Job assigned when injured | | Length of experience at this |
| Date of Injury | Time of Injury AM PM | Last day worked following injury |

Name / address of treating doctor (if none, write none)

Is this doctor your designated provider? YES ☐ NO ☐

Place of accident /injury exposure

What happened to cause the injury/illness?

Names of witnesses

Injury description (exact body parts affected & nature of injury)

Did the injury occur because of:

☐ Failure to use safety device ☐ Failure to obey safety rule

☐ Intoxication or drug abuse ☐ Other

Give details

Describe third party liability

The above is a true and correct statement of how the accident occurred and the extent of the injury.

Injured worker (signature) Date

Report prepared by (signature) Date