



FACT REPORT FOR EMPLOYEE INJURY

In the event of an Accident/Incident.

Report all claims Safety Dept.: 850-340-0348.

Date of Accident: 04/09/2018

Time of Accident: 06:37 AM Am/Pm

Name of Injured Employee: barbe lal

Location & Address of Accident/Injury: US

Supervisor:

Photo on File: Yes _____ No:
 No

Description of Accident (Tell how it happened):

Describe Injury:

Witness Name:

Tele:

Witness Name:

Tele:

Did Employee Receive Medical Attention: Yes: Yes No:

 was offered medical treatment and refused it at this time.

Employee Signature:

Date: 04/09/2018

Forman Signature:

Date: 04/09/2018

All forms must be completed and turned in within 24 hour.