SIMMONS COMPANY

WORK-RELATED INCIDENT /ACCIDENT/ INJURY INVESTIGATION REPORT

Injured Employee Name:			**Job Title:**	**Social Security Number:**
Employee Address:			**Employee Phone Number:**	**Date of Birth:**
Date of Hire:	**Base Rate:**		**# of Dependents:**	**Marital Status:**
Injury Date:	**Time:**		**Date Reported:**	**Shift start time on day of** injury:
Last Day Worked:	**Days missed from work:**	**Witnesses:**		**Supervisor and Operations Manager:**
Nature of injury and part of body:		**What was employee doing at time of injury:**		**Location of accident:**
Name and address of treatment facility:				**Phone Number of facility**
Date treated:	**Light Duty Restrictions:**			**Drug/ Alcohol Test administered?**
Emergency Responders:	**Any witness/responders exposed to bodily fluids under BBP policy?**			**Is this OSHA recordable?**

Describe how the accident occurred:

Causal factors:

Recommended Corrective Actions: (Those that have been or will be taken to prevent recurrence).

Signature of Person Completing Report: _____

Date: _____

Reviewed by: _____

Date: _____

Source: Occupational Safety & Health Administration, Washington, DC.

EMPLOYEE REPORT OF WORK-RELATED INJURY

Name _____ **Job Title** _____

Date of Injury _____ **Time of Incident** _____ **Dept. Where Incident Occurred** _____

Description of Incident - "What I was doing when I was injured." (Describe exactly what you were doing and what tools & equipment were involved and/or amount of weight being lifted.)

_____

_____

_____

_____

Body Part(s) Injured: _____

_____

_____

Type of treatment I received & where I was treated: _____

_____

Has this incident been reported to your Supervisor? If not, why not? _____

_____

_____

_____

Were there any witnesses to your injury? If yes, who? _____

_____

_____

_____

Were you using the required safety equipment for the job, (if no, why): _____

_____

_____

Suggestions I would like to make to help others avoid this type of injury: _____

_____

_____

_____

I certify that the above statements are true and accurate and I understand that the assertion of a false workers' compensation claim is a violation of many State criminal codes which may result in fines and/or imprisonment and will result in my being terminated from employment. I understand that this report will be a permanent record of this work-related injury.

_____

Employee Signature

_____

Date

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Source: Occupational Safety & Health Administration, Washington, DC.