Employer's Accident Report

Online: frankcrum.com/accident
Phone: 8:00 am – 5.30 pm, Monday – Friday at 1-800-393-0815 or 727-799-1229, option 5
After hours, weekends or holidays 888-443-3699
Fax: 727-725-7656

Client Company Name: _____

City: _____ County: _____

Contact Person: _____ Phone: _____

Injured Employee's Name: _____

Address: _____

Occupation: _____ Phone / Cell: _____

Date of Birth: _____ SSN: _____

Date of Accident: _____ Time: _____ **Full Time** **Part Time**

Date Employer Notified: _____ Last Worked Day: _____ Time Started Shift: _____

Return to Work Date: _____ Can You Accommodate Light Duty? **Yes** **No**

How Did the Accident Happen? What Was the Employee Doing? _____

_____

_____

Describe the Injuries and Name the Injured Body Parts: _____

_____

Place of Accident/ Address: _____

Immediate Supervisor: _____ Phone: _____

Agree with Description? **Yes** **No** Additional Comments: _____

_____

Witness Name: _____ Phone: _____

Are You Continuing to Pay Wages: **Yes** **No** Medical Attention: **Yes** **No**

Refused Med. Attention: **Yes** **No** Clinic/ Hospital's Name: _____

Phone/Contact: _____ Language of Choice (spoken and read): _____

Original Date of Hire: _____ Work Schedule (days and hours):

Health Insurance? **Yes** **No** Does company contribute to premium? **Yes** **No** Amount per month?

Completed by: _____ Title: _____ Date: _____

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Clearwater, Fl 33756

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