LUXE
HOTELS

LUXE SUNSET BOULEVARD HOTEL

EMPLOYEE ACCIDENT REPORT FORM

TO BE COMPLETED BY MANAGER

Employee Name_____ Social Security # _____ Hire Date _____

Marital Status _____ Dependents _____ Wage _____

Address_____ City_____ State____ Zip Code _____Telephone No.( )_____

Date of Birth _____ Sex: M_____ F_____ Job Title_____ Department _____

Immediate Supervisor_____ Title_____ Date Reported to Supervisor_____ Time_____

Date when accident was reported_____ Time _____ (AM/PM) Time workday began_____ (AM/PM)

Date of Accident_____ Time _____ (AM/PM) Paid full wages on the day of injury: Yes_____ No_____

Time lost after the accident _____ (If yes, please provide dates) _____

Specify work area where the accident occurred_____

Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill.

_____

_____

_____

_____

	YES	NO
Disabling Injury		
Sent to Hospital		
Send to Company Hospital		
Return to Regular Job		
Return to Light Duty Job		
First Aid Administered		
If employee refused medical attention, Have them complete the MEDICAL ATTENTION REFUSAL form.		
If Hospitalized, Name & Address of Hospital		

BODY PART INJURED
(Please Circle)

Eye
Head
Chest
Back
Abdomen
Arm
Hand-Finger
Leg
Foot-Toe
Respiratory System
Other _____

TYPE OF INJURY
(Please Circle)

Laceration
Abrasion
Puncture
Burn
Fracture
Strain-sprain
Amputation
Foreign body
Contusion
Other _____