OCC-4V (3-99)

OKLAHOMA CONSERVATION COMMISSION
ON-THE-JOB ACCIDENT REPORT
(COMPLETED BY THE EMPLOYEE)

This report should be made at the onset of occupational illness or immediately following an accident or injury.

CHECK ONE BOX ☐ **INJURY** ☐ **OCCUPATIONAL ILLNESS** ☐ **MOTOR VEHICLE**

NAME_____ SSN_____
(Must Be Completed)

ADDRESS_____
Number and Street City and State Zip Code

MARITAL STATUS

TELEPHONE NO._____ AGE_____ SEX____ ☐ M ☐ S

HOURLY/MONTHLY WAGE $_____ LENGTH OF SERVICE_____
YRS. MOS.

DATE OF BIRTH_____ OCCUPATION_____

DATE OF ACCIDENT_____ TIME_____ DATE EMPLOYER NOTIFIED_____

PLACE OF ACCIDENT:_____
City County State

LAST DATE WORKED_____ DATE RETURNED TO WORK_____
(After Injury)

MEDICAL ATTENTION

TIME WORKDAY BEGAN_____ ☐ AM ☐ PM ☐ YES ☐ NO

TREATING PHYSICIAN_____

ADDRESS_____
Number and Street City and State Zip Code

NATURE OF INJURY_____
(Example: burn, cut, stress, sprain, fracture, etc.)

_____

_____

BODY PARTS INJURED_____
(Example: eye, finger, back. Indicate specifically "right/left", etc.)

_____

_____

_____

_____

COMPLETE FRONT AND BACK OF FORM

USE ADDITIONAL SHEET IF NECESSARY IN ORDER TO MAKE A COMPLETE REPORT

HOW DID ACCIDENT OCCUR? (DESCRIBE IN DETAIL) _____

_____

_____

_____

_____

_____

_____

_____

_____

WHAT WERE YOU DOING? (EXPLAIN IN DETAIL)_____

_____

_____

_____

_____

_____

_____

_____

_____

WHAT CAUSED INJURY? (Substance or Object)_____

WITNESS TO ACCIDENT_____PHONE NO._____

ADDRESS_____
Number and Street City and State Zip Code

WHAT PREVENTATIVE MEASURES COULD HAVE BEEN TAKEN?_____

_____

_____

SIGNATURE_____DATE_____
Employee