FIRST NOTICE OF ACCIDENT REPORT FORM

Obsidian HR requires notification within 48 hours: Email this completed form to Obsidian HR Service Department at help@obsidianhr.com as soon as possible immediately following any work-related accident; must be within 48 hours of occurrence. A post-accident drug test may be required following any work-related accident.

COMPLETED BY THE EMPLOYEE'S SUPERVISOR

Company name:

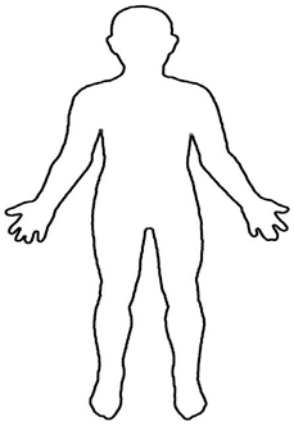
Injured person's name: Last First MI

Home address: City State Zip code

Home telephone number:	Work telephone number:	Cellular telephone number:
Social security number:	Date of birth:	Job title and department:
Date and time of accident / injury:	Location of accident / injury:	Date and time reported:

Name of immediate supervisor: Phone number of immediate supervisor:

Circle injured body part:



Specific body part(s) injured:

- ☐ right ☐ left EYE
- ☐ right ☐ left ARM
- ☐ right ☐ left HAND
- ☐ right ☐ left FINGER, which one:
- ☐ right ☐ left LEG
- ☐ right ☐ left FOOT
- ☐ right ☐ left TOE, which one:
- ☐ upper ☐ lower BACK
- ☐ HEAD ☐ NECK
- ☐ CHEST
- ☐ ABDOMEN
- ☐ RESPIRATORY

Type of injury

- ☐ Abrasion
- ☐ Amputation
- ☐ Burn
- ☐ Concussion
- ☐ Contusion
- ☐ Foreign body object
- ☐ Hernia
- ☐ Laceration
- ☐ Puncture
- ☐ Strain / sprain
- ☐ Other:

Was first aid required? ☐ Yes ☐ No	Was outside medical treatment needed? ☐ Yes ☐ No If "yes" provide medical facility and/or doctor's name:	Is a follow-up doctor visit required? ☐ Yes ☐ No

Is lost time expected? ☐ Yes ☐ No	Was personal protective equipment required? ☐ Yes ☐ No	Was personal protective equipment used? ☐ Yes ☐ No

Description of accident / injury:

What (if any) unsafe acts or conditions contributed to the accident / injury?

What actions will be taken to prevent such unsafe acts or conditions in the future?

Was the accident / injury caused by someone who is not on Obsidian HR's payroll? ☐ Yes ☐ No If "yes" provide their name and phone number:

Were there any witnesses to the accident / injury? ☐ Yes ☐ No If "yes" witness must complete WITNESS STATEMENT section on Page 2.

Supervisor signature:

Print name:	Date:

ACTIONS PRECEDING THE INCIDENT
COMPLETED BY THE EMPLOYEE

Please describe, in detail, the event(s) that resulted in the accident/injury. What, if anything, contributed to the accident/injury?
What were you doing at the time of the accident/injury?
What object or substance caused the actual injury?
What time did your shift begin?

Employee signature:	Date:

WITNESS STATEMENT
(Attach additional pages for multiple witness statements.)

Witness name:	Last	First	MI
Home address:	City	State	Zip code

Home telephone number:	Work telephone number:	Cellular telephone number:

Statement:

Witness signature:	Date:

FAX OR EMAIL COMPLETED ACCIDENT REPORT FORM TO *CLAIMS DEPARTMENT* AT 303-802-2055 OR help@obsidianhr.com AS SOON AS POSSIBLE IMMEDIATELY FOLLOWING ANY WORK- RELATED ACCIDENT