SMITH COUNTY ACCIDENT/INJURY REPORT
****MUST BE COMPLETED AND SENT TO PERSONNEL WITHIN 24 HOURS OF THE ACCIDENT OR INJURY****

Date of Accident: _____ Time of Accident: _____
Employee Involved: _____
(PRINT NAME)

Employee Statement of facts resulting in accident:
****Please Print****

_____
_____
_____
_____
_____
_____

Part of Body Injured or Exposed:

_____

Was Medical Attention Needed? If so, where:

_____
_____

Return to Work Date/or Expected Date: _____

Witness(s):_____

Witness statement:

_____
_____
_____
_____

Supervisor(s) statement:

_____
_____
_____

What specific action will be taken or implemented to prevent this type of accident?

_____
_____
_____

Traffic Accident: Yes __ No __ Police Called: Yes __ No __
****

Department Name _____

Supervisors Signature _____Date_____

Received by Personnel: _____

Personnel's fax number: (903) 590-4640

HR 1/06
Revised 1/07