

Complete all areas that apply, otherwise leave blank

Antelope Memorial Hospital Accident/Illness Report

PLEASE PRINT

This form complies with OSHA's Form 301 Injuries and Illnesses Incident Report

Employer Information

Company Name ANTELOPE MEMORIAL HOSPITAL/AMH CLINICS Case or File # _____

Mailing Address 102 w 9TH, BOX 229 City NELIGH State NE Zip 68756

Employee Information

Name _____ Job Title _____
LAST FIRST MIDDLE

Department _____ Social Security # _____

Phone (____) _____ Female ___ Male Date of Hire ____/____/____ Date of Birth ____/____/____

Facts of Accident/Illness

____ Illness ____ Injury Date(s) Off Work _____ # of Hours off Work _____

What is the illness/injury? (Be Specific) _____

Fatality? ___ Yes ___ No

For On The Job Illness or Injury (Complete information below)

Time began work ____ AM / PM Time of work related injury/illness ____ AM / PM Unknown _____

Location where incident occurred, (be specific). _____

Name of physician or other health care professional _____

What treatment was given? _____

Where? Facility _____ Address _____

Treated in emergency room? ___ Yes ___ No Hospitalized overnight as an in-patient? ___ Yes ___ No

What was employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or materials the employee was using. Be specific. _____

What happened? Tell us how the injury/illness occurred. _____

What object or substance directly harmed the employee? _____

Witness(s) _____

Prepared by _____ Job Title _____ Date of this Report ____/____/____