



EMPLOYEE'S REPORT OF ACCIDENT

9016 Philips Highway
Jacksonville, Florida 32256

Please Fax completed form to (904) 262-2760; Attention: Risk Management Dept.

EMPLOYEE'S NAME: _____ AGE: _____ SEX: _____
(PLEASE PRINT)

SOCIAL SECURITY NUMBER: _____ JOB POSITION: _____

CLIENT COMPANY: _____ CITY: _____

SUPERVIOR'S NAME: _____

DATE AND TIME OF ACCIDENT: _____

LOCATION OF ACCIDENT: _____

TASK BEING PERFORMED WHEN ACCIDENT OCCURRED: _____

TO WHOM THE ACCIDENT WAS REPORTED: _____

NAME(S) OF WITNESS (ES): _____

DESCRIBE HOW ACCIDENT OCCURRED: _____

PART OF THE BODY INJURED: _____

DESCRIBE ALL INJURIES IN DETAIL: _____

DATE AND TIME YOU FIRST SOUGHT MEDICAL ATTENTION: _____

NAME OF DOCTOR AND/OR FACILITY: _____

PLEASE CHECK THE BOX THAT YOU FEEL IS APPROPRIATE

- I require medical treatment and I will undergo a post-accident drug test and release the results to Matrix Employee Leasing and its designated representatives.
- I am refusing both medical treatment and a post-accident drug test. I understand that I may be required to pay all costs of my medical treatment if sought in the future.

Printed Name of Employee: _____

Signature of Employee: _____ Date: _____

MATRIX EMPLOYEE LEASING

9016 Philips Highway
Jacksonville, Florida 32256

Phone: (904) 739-2722 Fax: (904) 262-2760