Ord Sports Chiropractic & Wellness
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Workman's Comp Accident Form

ACCIDENT INFORMATION

Who saw the accident: Name: _____ Title: _____

Who reported the accident: Name: _____ Title: _____

Did you lift from: ☐Ground ☐Bench ☐Platform ☐Box ☐Pallet ☐Other

Do you use hand or foot levers: ☐Yes ☐No Do you work overhead: ☐Yes ☐No

Do you have to reach: ☐Yes ☐No Explain: _____

Is your work area cluttered: ☐Yes ☐No Explain: _____

Do you push or pull: ☐Yes ☐No Explain: _____

Do you pick up or lift: ☐Yes ☐No How Much: _____ How Often: _____

Do you lift in and out of a machine: ☐Yes ☐No If so, do you: ☐Sit ☐Stand ☐Kneel

Location of injury: _____ Date of injury: ____/____/____

Time of day injury happened: _____

Activity being performed: _____

Please describe the accident: _____

_____

_____

_____

WORKPLACE INFORMATION

Type of flooring: ☐Rough ☐Smooth ☐Wood ☐Concrete ☐Steel ☐Other

If other, explain: _____

Type of lighting: ☐Overhead ☐Fluorescent ☐On Machine ☐Other

If other, explain: _____

Is your work area: ☐Oily ☐Dirty ☐Slippery ☐Other

If other, explain: _____

Do you have any other jobs: ☐Yes ☐No

If yes, what type: _____

Type of windows: ☐Open ☐Closed ☐No Windows

Type of shop: ☐Union ☐Non-Union

Are you tired when you go home: ☐Yes ☐No