



IAM&AW Accident Reporting Form

Industry:

- | | | | |
|--------------------------|----------------|--------------------------|---------------|
| <input type="checkbox"/> | Aerospace | <input type="checkbox"/> | Airline |
| <input type="checkbox"/> | Automotive | <input type="checkbox"/> | Government |
| <input type="checkbox"/> | Machining | <input type="checkbox"/> | Manufacturing |
| <input type="checkbox"/> | Maritime | <input type="checkbox"/> | Railroad |
| <input type="checkbox"/> | Transportation | <input type="checkbox"/> | Woodworking |
| <input type="checkbox"/> | Other | | |

Name of Employer:

Name of Injured Member (Optional):

Gender:

- Male Female

Age Group:

- 18 – 30 31 – 40 41 -50
- 51 – 60 Over 60

Date of Accident:

Submitted by:

District Lodge #:

Local Lodge #:

Type of Work:

Shift Worked:

- First (days)
- Second (nights)
- Third (graveyard)

Rotating Shift:

No

Yes

Type of Injury/Illness:

Abrasions

Amputations

Back

Breaks

Bruises

Burns

Cuts & Lacerations

Musculoskeletal Disorders

Respiratory Problem

Skin Problems

Added Details:

Area Injury Occurred:

Upper Body - Left Side

Arm

Chest

Elbow

Finger

Hand

Shoulder

Torso

Wrist

Upper Body – Right Side

Arm

Chest

Elbow

Finger

Hand

Shoulder

Torso

Wrist

Lower Body – Left Side

Ankle

Foot

Hip

Knee

Leg

Pelvic

Toe

Lower Body – Right Side

Ankle Foot Hip Knee

Leg Pelvic Toe

Misc Body:

Head Spinal

Lost Work Days:

N/A Week (1-7 days) 1 – 4 Weeks

1 – 6 Months Permanent Disability

What type of permanent disability? (only for permanent disability above)

Did Member die as a result of the accident?

No Yes

Date of Death: (If Known)

If citation was issued, what government agency issued it and what was it for:

Submitted By:

Phone Number:

E-Mail Address:

Union Position: