Sherwood Management Co., Inc.
Accident Report

SMC Department Name or
Store Number/Location: _____ Date of Accident: _____

After ANY accident or injury occurring in the store/department:

- Provide necessary first aid, refer to medical treatment or call 911-emergency, if necessary.
- Call Loss Prevention and report the incident:
  - During normal, week day business hours, call Human Resources/Loss Prevention at (310) 846 5618
  - After normal, week day business hours, call Cary Straus at (818) 383-6400
- Complete sections #1 and #2 of this form and FAX immediately to SMC Benefits at (310) 665-2151
- After completing section #3, send original to SMC Benefits

Section #1: Was anyone injured or did anyone get sick? [ ] Yes - [ ] No

If "NO" skip to Section #2 below

A. Name of person injured/ill: _____

B. Check one [ ] Company Employee- Emp. # _____ - [ ] Customer - [ ] Other

If the injured/ill person is NOT an employee, write their address and telephone number below:

Address: _____

City, State ZIP: _____

Phone: (_____) _____

C. Was first aid given? [ ] Yes - [ ] No
If first aid was given, by who (check one)?

[ ] Company Employee-Employee Number/Name: _____

[ ] Another Customer-Name: _____

[ ] Mall Security Guard/Other-Name: _____

[ ] Paramedic/Fire/Police Responder-Agency: _____

[ ] Other: _____

D. **FOR Injured Employees ONLY**: Did the employee return or was the employee available to return to work immediately? [ ] Yes - [ ] No

E. **FOR Injured Employees ONLY**: The supervisor in charge or the person completing this form **SHOULD** offer a workers compensation claim form for **ANY** injury requiring **MORE THAN** in-store/in-department first aid, e.g., more than a bandage, aspirin or cold pack, **AND** should provide a workers compensation claim form **WHENEVER REQUESTED** by the injured worker, regardless of the severity of injury. The workers compensation claim form (DWC-1) is available on the Intranet. – Please complete the following:

I [ ] did [ ] did NOT offer DWC-1 Workers Compensation Claim Form.

The injured worker [ ] did [ ] did NOT accept it or ask for a Workers Compensation Claim Form

F. Was this person referred to medical treatment? [ ] Yes - [ ] No
If yes, indicate referral below AND give a referral form to the injured person)

Treatment Location: _____

Address: _____

City, State ZIP: _____

Phone: (_____) _____

Section #2: Describe the accident

A. Indicate the date and time the accident occurred: Date: _____ Time:_____ [ ] AM - [ ] PM

B. If accident at a store location, was the store closed at the time of the accident? [ ] Yes - [ ] No

C. Injury location within the department or store or elsewhere? For example, “in the bathroom”, “near the diamond case”, “in the office near the FAX machine”. Be as descriptive as possible:

_____

_____

D. How did the accident occur? Be as descriptive as possible:

_____

_____

E. List the name and contact number of each employee, customer or other witness to the accident:

_____

F. If anyone was injured, how were they injured? Also, described which part of his/her body was injured?

_____

_____

G. Describe any damage to company, employee’s or other person’s property as a result of this accident.

_____

Sections #1 and #2 of this form were completed by: (print name):_____

Signature: _____Date: _____

Section #3: Action Taken to Prevent This In Future:

Call Human Resources/Loss Prevention at (310) 846 5618 before completing this section:

_____

_____

Section #3 of this form was completed by: (print name): _____

Signature: _____Date: _____

SMC Use Only			
Accident Report	Received:		
LP Investigation Incident # _____	Sent:	Received:	Routed:
DWC-1 Form	Sent:	Returned:	Forwarded:
Claim Form:	Sent:	Returned:	Forwarded: