NCDOL
N.C. Department of Labor

Cherie Berry
Commissioner of Labor

Accident Reporting Form

(Effective January 1, 2015)

Employer Name:		
Site Address:		
Mailing Address:		
Event Address (If different):		
Number of Employees at Establishment:	SIC Code:	NAICS Code:
Type of Business: (if construction, indicate commercial / residential)		
Reported By:		
Job Title:	Telephone Number:	
Date and Time Reported:	Date and Time of Accident:	
Event Description/Type of Injury:		
Number of Injuries:	Number Hospitalized:	Number Still Missing:

Name of Victim:			
Gender:	Race:	Age:	Date of Birth:
Type of Event: ☐ In-patient Hospitalization	☐ Amputation	☐ Loss of an Eye	
Next of Kin Name:			
Next of Kin Address:			
Next of Kin Relationship:			

Name of Victim:			
Gender:	Race:	Age:	Date of Birth:
Type of Event: ☐ In-patient Hospitalization	☐ Amputation	☐ Loss of an Eye	
Next of Kin Name:			
Next of Kin Address:			
Next of Kin Relationship:			

Person in Charge at the Scene:

Suggestion: *Save this as a document for your records and send as an email attachment to complaint.desk@labor.nc.gov or use the "Submit Form" button.*

Submit Form **Reset Form**