EMPLOYEE'S REPORT of an ACCIDENT

(to be filled out for all on-the-job injuries or illnesses)

Employees name: _____

Job Title: _____

Exact time of injury: _____ Date of injury: _____

Campus location where injury occurred: _____

To whom was this incident was reported: _____ Time: _____

Names of witnesses: _____

Summarize what happened: _____

_____

_____

What changes, if any could be made to avoid a similar accident?

_____

_____

Explain in detail what part of your body was injured, please be specific: _____

_____

_____

_____

Is this an original injury or a re-injury? _____

If a re-injury, when and where was the original injury: _____

Who was the employer? _____ Claim # _____

Are you willing to perform modified duty during your recovery? _____

Date and time you sought medical attention: _____

Physician's name: _____ Location: _____

Complete and return this form to your supervisor as soon as possible

Employee's signature: _____ Date: _____

REPORT ALL ON-THE-JOB INJURIES OR ILLNESSES –

NO MATTER HOW MINOR THEY SEEM AT THE TIME !