



EMPLOYEE ACCIDENT REPORT

PART I Employee must complete and answer all questions		Today's Date	Time	A.M. <input type="checkbox"/>
				P.M. <input type="checkbox"/>

First Name	Middle Initial	Last Name	Social Security #	Birth Date	Age
------------	----------------	-----------	-------------------	------------	-----

Home Address (Number & Street)	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Marital Status	Home Telephone
--------------------------------	--	----------------	----------------

City	State	Zip	Your Job	Department in which you are employed
------	-------	-----	----------	--------------------------------------

Exact area/location of accident	Date & time of accident	A.M. <input type="checkbox"/>
		P.M. <input type="checkbox"/>

Approximate length of time worked with College	Part(s) of body affected/injured
--	----------------------------------

Employee's description of accident in full (walking downstairs, lifting, etc.)

Witnesses names, if any

PART II Immediate Medical Treatment

Date of immediate treatment

Where:

Diagnosis:

APPROXIMATE RETURN TO WORK DATE:

PART III To be completed by supervisor to whom accident reported	Did you physically inspect the area where injury occurred? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Was the accident reported to you immediately?

Supervisor's Name & Title

If no, when did you learn of the accident?

Was the employee at work and on company time? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was employee intoxicated or misconducting himself? Yes <input type="checkbox"/> No <input type="checkbox"/>
---	--

If yes, explain:

Are you satisfied this accident occurred as described?	Action taken to prevent recurrence
--	------------------------------------

Were hazards reported, if so, to whom?

Do you want to discuss this matter further with the Claims Administrators? Yes No

If yes, telephone number where you can be reached:

Date

Supervisor's Signature and Title
