WORKERS' COMPENSATION REPORT OF INJURY

EMPLOYEE NAME: _____ DEPT NUMBER: _____

HOME ADDRESS: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____ a.m. _____p.m.

DATE SUPERVISOR NOTIFIED OF ACCIDENT: _____

WHAT WAS EMPLOYEE DOING WHEN THE ACCIDENT OCCURRED? _____

_____

HOW DID THE ACCIDENT HAPPEN? (DESCRIBE IN DETAIL ALONG WITH BUILDING, ROOM NO.) _____

_____

_____

PLEASE PROVIDE PICTURES OF ACCIDENT SCENE & EQUIPMENT USED DURING ACCIDENT.

TYPE OF INJURY: _____

WHAT BODY PARTS WERE AFFECTED? _____

NAME OF DOCTOR WHO TREATED EMPLOYEE: _____

STATE LOSS OF TIME FROM WORK: _____

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?_____YES_____NO

WERE THEY USED?_____YES_____NO

NAME OF WITNESS:_____TELEPHONE #: _____

DOES EMPLOYEE HAVE 2ND JOB? IF YES, NAME & PHONE # OF EMPLOYER: _____

CIRCUMSTANCES, WHICH LED TO ACCIDENT: _____

_____

_____

_____

EXPLAIN HOW THIS ACCIDENT *WILL BE PREVENTED* IN THE FUTURE: _____

_____

EMPLOYEE'S SIGNATURE: _____ DATE: _____

SUPERVISOR'S SIGNATURE: _____ DATE: _____

PLEASE RETURN TO RISK MANAGEMENT ONCE COMPLETED