EMPLOYEE OCCUPATIONAL ACCIDENT/INJURY REPORT

CASE NUMBER: ______________________ TODAY'S DATE: ______________________

A. EMPLOYEE INFORMATION:

1. NAME: ______________________
2. HOME ADDRESS: ______________________
   CITY: ______________________ STATE: __________ ZIP: __________
3. EMAIL ADDRESS: ______________________
4. PHONE (Work): __________ (Home): __________ (Cell): __________
5. DATE OF BIRTH: ______________________ 6. SEX: ______ M ______ F
7. JOB TITLE: ______________________
8. DEPARTMENT: ______________________
9. SUPERVISOR: ______________________
10. SUPERVISOR'S PHONE: ______________________

B. SYNOPSIS OF ACCIDENT:

1. CIRCUMSTANCES OF ACCIDENT/INJURY:
   a. Location of Accident: ______________________
   b. Date and Time of Accident: ______________________ ______ A.M. ______ P.M.
   c. Activity Engaged In: ______________________
   ____
   ____
   d. How Accident/Injury Occurred: ______________________
   ____
   ____
   e. Witnesses (Name, Department and Phone Number): ______________________
   ____
   ____
   ____
2. EMPLOYEE FIRST BECAME AWARE OF INJURY:
   a. Date: __________ b. Circumstances: ______________________
   ____

CONTINUED ON REVERSE SIDE

3. NOTICE TO UNIVERSITY OF ACCIDENT/INJURY:
   a. Date Notice Given: ______________________________
   b. Notice Given By: ______________________________
   c. University Employee to Whom Notice Given: ______________________________
4. OTHER INFORMATION: ______________________________

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C. INJURY AND TREATMENT:

1. TYPE AND DESCRIPTION OF INJURY: ______________________________

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2. IMMEDIATE PROFESSIONAL MEDICAL ATTENTION:
   a. Employee: ____________ Secured ____________ Did Not Secure
   b. Supervisor: ____________ Required ____________ Did Not Require
3. IF DETERMINATION WAS MADE BY UNIVERSITY EMPLOYEE OTHER THAN SUPERVISOR, GIVE NAME AND POSITION: ______________________________
4. INITIAL TREATMENT:
   a. Date and Time of Treatment: ______________________ ________ A.M. ________ P.M.
   b. Physician or Hospital: ______________________________
   c. Summary: ______________________________

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5. ADDITIONAL TREATMENT: ______________________________

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6. ADDITIONAL INFORMATION: ______________________________

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