



ACCIDENT/INJURY REPORT

Check One

Employee

Student

Visitor

Please type or print and return to the Office of Human Resources within 5 days from date of injury

Name				Today's Date			
Address				Married	Single	Widowed	Divorced
City		State		Zip		Phone #	
SS#	Birthdate	Job Title & Hours Worked		Date of Hire	# Work Days Lost		
Date of Injury		Time	(If employee)				
Date returned to work (if employee)				Place where injury occurred			
Date notified College				Date treated by Physician			
Attending Physician/Address						Phone #	
Hospital						Date hospitalized	
Nature of Injury							
Part of body injured				Left	Right	Both	Type of Injury: (Cut, Bruise, etc.)
State how injury occurred							
Witnesses							
If injury was caused by another person not in our employ, give name and address:							
Remarks							
SIGNATURE OF INDIVIDUAL INJURED							
SIGNATURE OF EMPLOYEE'S SUPERVISOR						DATE	