

EMPLOYEE OCCUPATIONAL ACCIDENT 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: \_\_\_\_\_

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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. INJURY AND TREATMENT:

1. TYPE AND DESCRIPTION OF INJURY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. ADDITIONAL TREATMENT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. ADDITIONAL INFORMATION: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

X \_\_\_\_\_

X \_\_\_\_\_

SIGNATURE OF INJURED EMPLOYEE