Departmental Accident Report

Note: The Worker's Compensation Board and OSHA require that a report of any job-related injury or illness involving a College employee be filed with the Board WITHIN TEN DAYS after the date of the injury or onset of illness. Please send this report to: DEPARTMENT OF HUMAN RESOURCES, retaining sufficient copies for your own files.

EMPLOYEE'S PERSONAL INFORMATION

1. Name: _____ 2. Date of Birth: _____/_____/_____

3. Mailing Address: _____

4. Social Security Number: _____ 5. Contact Phone Number: (____) _____

6. Gender: □ Male □ Female

EMPLOYEE'S INJURY OR ILLNESS

1. Time of day employee began work on date of injury: _____□ AM □ PM

2. Time of injury: _____□ AM □ PM 3. Has the employee given you notice of injury/illness? □ Yes □ No

If yes, notice was given to: _____ □ orally □ in writing Date notice provided: _____/_____/_____

If available, attach a copy of the employee's written notice and medical notes, and the employer's incident report.

4. Where did the injury/illness happen? (e.g., Main. Front Door) _____

_____

5. Was this location where the employee normally worked? □ Yes □ No If no, why was the employee there?

_____

6. Employee's supervisor: _____ 7. Did supervisor see injury happen? □ Yes □ No □ Unknown

8. Did anyone else see the injury happen? □ Yes □ No If yes, give name(s): _____

9. What was the employee doing when he/she was injured or became ill? (e.g., unloading a truck, stocking a shelf, etc) _____

_____

_____

_____

_____

10. How did the injury/illness occur? (e.g., the employee tripped over a pipe and fell on the floor) _____

_____

_____

_____

11. Explain fully the nature of the employee's injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead):

_____

_____

12. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? □ Yes □ No

If yes, what was it? _____

13. Was the injury the result of the use or operation of a licensed motor vehicle? □ Yes □ No

If yes, □ employee's vehicle □ employer's vehicle □ other vehicle License plate number (if known) _____

If employer's vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

_____

14.Name and address of the nearest relative: _____

MEDICAL TREATMENT

1. What was the date of the employee's first treatment? ____/____/____ □ None received □ Unknown

2. Where did the employee receive first medical treatment for this injury/illness? □ On site □ Doctor's office □ Emergency Room □ Clinic/Hospital/Urgent Care □ Hospital Stay over 24 hours □ Unknown

Who treated the employee and where? _____

3. Is the employee still being treated for this injury/illness? □ Yes □ No □Unknown If yes, name and address of treating doctor(s): _____

4. To your knowledge, did the employee have another work-related injury to the same body part or a similar illness while working for you? □ Yes □ No If yes, name the doctor(s) who treated the previous injuries/illnesses (if known):

_____

_____

RETURN TO WORK

1. Did the employee stop work because of his/her injury/illness? □ Yes □ No If yes, on what date _____/_____/_____

2. Has the employee returned to work? □ Yes □ No If yes, on what date _____/_____/_____ □ Regular duty □ Limited duty

EMPLOYEE'S WORK INFORMATION on the date of the injury or illness

1. What was the employee's job title? _____

2. What types of activities did the employee normally perform at work? (Attach job description if available.)_____

_____

_____

EMPLOYEE'S PAYROLL INFORMATION on the date of the injury or illness

1. Did the employee receive lodging or tips in addition to pay? □ Yes □ No

If yes, describe: _____

2. Employee's job was (check one): □ Full Time □ Part Time □ Seasonal □ Volunteer □ other: _____

_____

3. Which days of the week did the employee usually work? □ Mon. □ Tues □ Wed. □ Thurs. □ Fri. □ Sat. □ Sun.

4. What are the employee's normal working hours? _____

5. Did accident occur during over time? □ Yes □ No

5. Was the employee paid for a full day on the day of the injury/illness? □ Yes □ No

ADDITIONAL INFORMATION

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