



## **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**