



**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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