EMPLOYEE ACCIDENT REPORT
Part 1: Employee Accident and Investigation Report

1. Employee Name _____

2. Employee SSN (last four digits)_____ 3. Date of Birth _____

4. Address _____

5. Home Telephone _____

6. Campus Job Title_____

7. Date of Accident _____ 8. Time of Accident _____

9. Place of Accident _____

10. Employee's Work Location _____

11. Shift Hours _____ 12. Pass Days _____

13. Employee Remained on Duty ( ) Yes ( ) No

14. Employee Required Medical Attention ( ) Yes ( ) No

Type: First Aid Ambulance Walk-In Primary Care Emergency Room

Required: X-Rays Prescription Physical Therapy Other _____

15. Statement of Employee: _____

_____

_____

_____

16. Signature of Employee _____ 17. Date _____

18. Names of Eyewitness with Statement: _____

_____

_____

_____

19. Supervisor's Statement: _____

_____

_____

20. Supervisor's Signature_____21. Date _____

22. Date Employee First Absent _____

C2128-681

(OTHER THAN A MOTOR VEHICLE ACCIDENT)