ALBION COLLEGE

Work-Related Injury Report Form

This form should be completed and submitted to the Human Resources office as soon as possible after an injury. The injured employee should complete this report form, or the supervisor, if the employee is unable.

PERSONAL INFORMATION

Print Employee Name (Last, First, MI): | Today's Date

Home address (street, city, zip) | Birth date

Home phone number | Work phone number | Hire date

Job Title | Rate of Pay

Social Security# | Supervisor's name & phone extension

☐ Full-time ☐ Part-time Hours/day_____ Days/ week_____ Work day start time _____

INJURY / ACCIDENT INFORMATION

Date of Injury | Time of injury | Did injury cause loss of time from work? (dates, amount of time)
☐ yes ☐ no

Has employee returned to work?
☐ yes ☐ no

Provide names of any witnesses to the accident/injury:

Describe injury: What parts of the body were affected? What type of injury?

Describe what happened (where the employee was, what he/she was doing and how the injury occurred):

TREATMENT

Describe any First Aid given at the scene of the accident/ injury:

Was injured treated in an emergency room? ☐ yes ☐ no
Name of treating doctor, if known

Taken by ambulance? ☐ yes ☐ no
Name medical provider(s):

Address (street, city, state, zip) | phone number

Treatment received

Employee signature:_____Date_____
Supervisor signature:_____Date_____

Travelers Claim Number _____ OSHA Number _____