

EMPLOYEE ACCIDENT STATEMENT FORM

Injured Employee's Name: _____

Phone Number: _____ Email: _____

Job Title: _____ Department: _____

Supervisor: _____ Supervisor's Email: _____

Date of Accident: _____ Time of Accident: _____

Specific Location of Accident (include campus, bldg., room, etc): _____

Witnesses of Incident: _____

Duties being performed when accident occurred: _____

Describe fully how accident occurred (including events that occurred immediately before the accident):

Describe bodily injury sustained (be specific about body part(s) affected):

Recommendation on how to prevent this accident from recurring:

Signature of Employee (as shown on payroll)

Date Signed