ABRAHAM BALDWIN AGRICULTURAL COLLEGE

EMPLOYEE'S REPORT OF INJURY

_____(To be completed by the employee only.)_____

Employee's name:_____ Male___ Female___
Last First Middle

Date of birth:___/___/____ Home telephone#(_____) _____

Home address:_____

City:_____ State:_____ Zip Code:_____

Present classification:_____ How long employed here:_____

Social Security No.: _____-_____-_____ Weekly salary:_____

Location of accident:_____
Address Area (loading dock, bathroom, etc.)

Date of accident:_____ Time of accident:_____

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: _____

_____

Name of supervisor: _____ Phone#_____
Last First

Name(s) of witness(es):_____Phone#_____
(Attach witness(es) report(s)

When did you report the accident to your supervisor?_____

To whom did you report the injury?_____

Do you require medical attention? Yes:_____ No: _____ Maybe:_____

Name of your treating physician: _____ Phone#_____

Signature of employee:_____ Date: _____

Department of Administrative Services
Risk Management Services
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