

SKIDMORE COLLEGE

Accident Reporting Form for Employees and Student Employees

This form should be faxed to
Human Resources at ext. 5805
within 24 hours of accident by
the Supervisor

Form Should Be Completed By The Supervisor While Interviewing Employee

Complete and check all that apply

Date of Injury: (mm/dd/yy)	Time of Injury: _____ <input type="checkbox"/> am <input type="checkbox"/> pm	Shift Began: _____ <input type="checkbox"/> am <input type="checkbox"/> pm	Accident happened while on duty: <input type="checkbox"/> Yes <input type="checkbox"/> No
Print Name (Last, First, MI):		Date of Birth: (mm/dd/yy)	Employee ID Number:
Home Address: Street _____ City _____ State _____ Zip _____			Home Telephone Number: Cell Number:
First Full Lost Work Day Due to Injury: (mm/dd/yy)	Regular Work Shift: from _____ <input type="checkbox"/> am <input type="checkbox"/> pm to _____ <input type="checkbox"/> am <input type="checkbox"/> pm		
Medical Care Provided on Day of Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No	Regular Days Off:		
Medical Care Provided By:	Date Medical Care Provided: (mm/dd/yy)		
If medical care or lost work time is a result of a previous accident, indicate date of original accident: (mm/dd/yy)			
<input type="checkbox"/> Employee <input type="checkbox"/> Student Employee	Job Title:		
Employee's Date of Hire: (mm/dd/yy)	Job Dept.:		
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time			
Specifically where did the injury occur (i.e. dining hall kitchen, Starbuck 1 st floor stairwell, walkway in front of Facilities):			
Part(s) of body injured (i.e. left arm, lower back):			
Nature of Injury (i.e. cut, sprain, rash, pulled muscle, bruised):			
What were you doing when the accident or exposure happened?			
Witnesses to accident:			
Explain exactly how the accident or exposure happened and list the causes of the accident/exposure:			
Were you wearing safety shoes? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you wearing cut resistant gloves? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you wearing safety glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you wearing/using other Safety equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No
I confirm that the information furnished above is true and complete to the best of my knowledge:			
Employee's/Student Employee's Signature:			Date:
Supervisor's Signature:			Date:
Supervisor to complete upon Employee's / Student Employee's return to work and fax to Human Resources at extension 5805 with physician's release (Employee must bring in release from Physician before resuming work)			
Return to Work Date: (mm/dd/yy)	<input type="checkbox"/> Return to Modified Duty	<input type="checkbox"/> Return to Full Duties	
Supervisor's Signature:			Date:

SUPERVISORS' ACCIDENT INVESTIGATION REPORT

(To be completed by the Supervisor)

EMPLOYEE'S INFORMATION (type or print)			
INJURED EMPLOYEE'S NAME:	ACCIDENT DATE:	ACCIDENT TIME:	ACCIDENT DAY OF WEEK:
JOB TITLE AND DEPARTMENT:			
FIRST FULL LOST DAY DUE TO INJURY:	<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE	<input type="checkbox"/> STUDENT	<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME
IMMEDIATE SUPERVISOR:	EXACT LOCATION OF ACCIDENT:	DATE REPORTED BY EMPLOYEE:	
PERSON WHO RECEIVED FIRST NOTICE:	WITNESSES:		
DESCRIBE HOW THE INCIDENT OCCURRED:			
PART(S) OF BODY AFFECTED (include left or right. E.g. Left lower back):			
NATURE OF INJURY/ILLNESS (e.g. Strain, laceration, contusion, cut, sprain, rash pulled muscle):			
CAUSE OF INJURY (e.g. Slip or fall, struck by, cut or puncture, etc.):			
LIST ROOT CAUSES (UNDERLAYING): (e.g. Inadequate enforcement of work rules and procedures or lack of proper job procedures)			

SUPERVISOR'S ACCIDENT INVESTIGATION FORM, PAGE 2

LIST THE ACTIONS THAT HAVE BEEN OR WILL BE TAKEN TO REMOVE CAUSES LIST ABOVE:	ACCOUNTABLE PARTY:	COMPLETION DATE

AS A SUPERVISOR, WHAT ADDITIONAL ACTIONS WILL YOU TAKE AS A RESULT OF THIS EMPLOYEE'S ACCIDENT?

INVESTIGATED BY:	DATE:	REVIEWED BY:	DATE:
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Please Complete the Supervisor's Accident Investigation Form and Forward To the Department Director Within 5 works Days of the Date of Accident.