

Andrews University Supervisor's Accident Report Form

Employee Information

Full Name _____ ID # _____
(First name) (Middle initial) (Last name)

Address _____
(Street) (City) (State/Zip)

Phone # _____ Date of Birth ____ / ____ / ____ Sex: M F Is the employee a student? Yes No

Department _____ Job Title _____ Date of hire ____ / ____ / ____

Injury Information

Last day worked ____ / ____ / ____ Date employee returned to work (if applicable) ____ / ____ / ____

Date of injury ____ / ____ / ____ Did injury occur on employer's premises? Yes No

Time employee began work _____ AM PM Time of Event _____ AM PM

Where was employee working when injured? _____

What was employee doing just before the incident occurred? Be specific _____

What does employee say happened that caused the injury? _____

What object or substance directly harmed the employee? (if applicable) _____

Describe injury or disease _____

Part of body directly affected by the injury or disease _____

Measures taken to prevent similar accidents _____

Who witnessed the injury? (Name) _____

Treatment Information

Was first aid administered in the department? _____

Was employee sent to UMS? _____ If so, on what date? ____ / ____ / ____

Physician (Name) _____ Hospital (if necessary) _____

Supervisor's Signature

Department

Instructions to Supervisor

- Administer first aid in the department.
 - ▶ If immediate attention is necessary, please call University Medical Specialties (473-2222) and notify them with the name of the employee that is to receive treatment.
- Ensure that this form is faxed to Workers' Compensation (extension 6293), located in Human Resources, immediately after the accident. Once received Workers' Compensation will generate a LakelandCare Treatment and Follow-up form for the provider.