

**Personal Injury Report**  
Andrews University

**To be completed by the injured person.**

**Information about you**

Your name \_\_\_\_\_ Daytime phone \_\_\_\_\_ Your age \_\_\_\_\_

Home address \_\_\_\_\_

Your employer \_\_\_\_\_ Your occupation \_\_\_\_\_

**Information about the accident**

1. Was the accident job-related? \_\_\_\_\_

If yes, please see your employer about workers' compensation benefits.

2. Where did the accident occur (be as specific as you can). \_\_\_\_\_

3. What were the date and time that the accident occurred? \_\_\_\_\_

4. What was the nature of your injury? \_\_\_\_\_

5. Please describe what happened. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

6. What were you doing when the accident happened? \_\_\_\_\_

7. What were the weather conditions when the accident occurred? \_\_\_\_\_

8. Did anybody see the accident happen? \_\_\_\_\_

If so, provide their names and phone numbers.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

**Follow-up information**

1. Did you receive medical treatment? \_\_\_\_\_ If so, on what date(s)? \_\_\_\_\_

Who was the medical provider? \_\_\_\_\_

2. As of today (the date you are completing this form), do you still have any symptoms related to this accident? If so, please describe them. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Your signature \_\_\_\_\_ Date \_\_\_\_\_

**For office use**

|                                |  |
|--------------------------------|--|
| RHH notified (date)            |  |
| Investigation requested (date) |  |
| Notes                          |  |

