

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 was 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	