

Record of Accident or Injury

Name of injured _____ Date of injury _____

Department _____ Time of injury _____ AM PM

Please Check One: Is injured Employee Student Visitor

If employee, shift begin time _____ Shift end time _____

Address of Injured _____
Street Address City State Zip Code

Phone number of injured _____ Email of injured _____

Regular Occupation _____

Occupation at time of injury _____

Injured while on the job Yes No Did accident/injury occur indoors or outdoors?

Describe type of floor/ground surface (i.e. wood, tile, carpet, concrete, grass, etc.) _____

Were there any apparent defects in the ground or floor, such as broken or uneven concrete, warped wood, etc? If yes, please describe _____

Location of accident/injury (include city, state and county) _____

Describe fully the events which resulted in the accident or injury. Include what employee individual was doing prior to and during accident (include any tool, equipment, machinery, etc, being used).

Were there any signs of drug or alcohol use? Yes No

Was safety equipment provided? Yes No If yes, please describe _____

Was there a machine part involved? Yes No. If yes, describe _____

If employee, date last worked _____ If employee, was salary continued _____

What part of the body was injured (please be specific)? _____

Did the injured individual receive medical treatment? Yes No

If yes, provide name and address and phone number of medical facility treating the individual _____

Was the individual transported to medical facility by ambulance? Yes No

If no, please provide name and contact information of individual transporting injured to medical facility _____

Names and addresses of any witnesses to the accident or injury _____

Name of individual accident/injury reported to _____

Date and time individual first reported accident/injury _____

If employee, number of days expected to be away from work _____

Does individual have any previous claims/injuries on record? Yes No

If yes, what was the date of injury? _____ What body part was injured? _____

Form completed by _____

Title _____ Date _____

Distribution: Provide original form to Human Resources, Attn: Risk Management
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