SUNY New Paltz

Report of Work-Related Accident or Injury (other than a motor vehicle accident)

EMPLOYEE INFORMATION

NAME:	DATE OF BIRTH:
ADDRESS:	LAST 4 DIGITS OF SOCIAL SECURITY NUMBER:
PHONE NUMBER(S):	SEX: MALE FEMALE
JOB TITLE:	REGULAR PASSDAYS:
REGULAR WORK SHIFT: START: AM/PM FINISH: AM/PM	TIME THAT EMPLOYEE BEGAN WORK ON DATE OF ACCIDENT: AM/PM
DEPT. WHERE EMPLOYEE IS REGULARLY ASSIGNED:	EMPLOYEE'S SUPERVISOR:

WORK-RELATED ACCIDENT/INJURY INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT: AM/PM
SPECIFIC LOCATION OF ACCIDENT:	WAS EMPLOYEE IN AUTHORIZED AREA? YES NO
DID ACCIDENT INVOLVE PERSONAL INJURY? YES NO	PART OF BODY INJURED:
DESCRIPTION OF INJURY:	DID EMPLOYEE MISS WORK BEYOND DATE OF ACCIDENT? YES NO
WERE SAFEGUARDS PROVIDED? YES NO	WERE SAFEGUARDS IN USE? YES NO
DID EMPLOYEE RECEIVE FIRST AID? YES NO	DID EMPLOYEE RECEIVE OTHER MEDICAL ATTENTION? YES NO
NAME AND ADDRESS OF PHYSICIAN OR HOSPITAL:	

DETAILS OF ACCIDENT AND LIST OF ANY WITNESSES (WHO, WHAT, WHEN, WHERE, & HOW IT HAPPENED):

REPORT INFORMATION

REPORT COMPLETED BY:	REPORTER'S ADDRESS:
DATE REPORT COMPLETED:	REPORTER'S PHONE NUMBER(S):
SIGNATURE OF REPORTER:	DATE THAT SUPERVISOR WAS NOTIFIED:

TO BE COMPLETED BY IMMEDIATE SUPERVISOR (explain in detail, use extra paper if needed)

WHAT CAUSED THIS ACCIDENT?	
CORRECTIVE ACTION TAKEN TO PREVENT FUTURE ACCIDENTS OF THIS KIND & TARGET DATES:	
SIGNATURE:	DATE: