New Paltz
STATE UNIVERSITY OF NEW YORK

Human Resources, Haggerty 203, (845) 257-3171 Fax: (845) 257-3621

ACCIDENT REPORT

Name _____
Last First Middle Initial

X	X	X	X	X				

Social Security Number

Address _____ Date of birth _____

Phone numbers(s) _____ Sex ☐ Male ☐ Female

Job title _____ Regular passdays _____

Regular work shift Start _____ AM PM Finish _____ AM PM Dept. assigned _____

Time that employee began work on date of accident _____ AM PM 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 supervisor 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 and target dates:

Print Name _____

Signature _____ Date _____