Please complete this form and return to the Human Resources Office within 24 hours of the time of the accident

ST. JOHN FISHER ACCIDENT REPORT FORM

SECTION 1: INJURED PERSON'S REPORT (Please use the back of the report for more room.)

Full Name of Injured Person: _____ Department: _____ Title: _____

Address City/State/Zip: _____ Phone #_____

Date of Birth:_____ Date Hired:_____ (Please Check) Male__ Female__

Days Normally Worked_____ Hours Worked: _____ Shift _____

Injury Date: _____ Day of Week:_____ Occurrence Time: _____a.m. _____p.m.

Date employer notified: _____ Person who received the first notice? _____

Accident Description - describe how the incident had occurred_____
_____

Nature of Injury - state the nature of injury and part(s) of body affected (e.g. right knee, lower back, etc.)
_____

What were you doing just before the accident occurred? _____

Where did the accident occur (exact location) and facility? _____

How did the accident occur? _____

What factors led up to or contributed to the accident? _____

What were the weather conditions on the date of your accident? _____

What tools, equipment or substance was being used? _____

Was time away from work necessary? ____Y ____N Last Day Worked: _____ Disability Begin Date: _____

Name and address of any witnesses: _____

Have you been provided medical treatment? ___Y ___N Will you need medical treatment? ___Y ___N
Did you receive care on campus? ___Y ___N

If treatment was given away from the worksite, where was it given**?** **Please provide the Name/Address of provider**:
_____

Were you treated in the emergency room? ___Y ___N Were you hospitalized overnight as an in-patient? ___Y ___N

This accident must be reported to Safety and Security. Have you contacted Safety and Security? ___Y ___N

EMPLOYEE SIGNATURE: _____ DATE: _____

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SECTION II SUPERVISOR'S REPORT: PLEASE VERIFY THE INFORMATION IN SECTION 1

When did you first know of the injury? _____

List the direct cause(s). List both unsafe actions and unsafe conditions. _____
_____

List the root cause(s). _____
_____

List the actions that have been or will be taken to remove direct causes listed above by whom and when they are or will be done._____
_____

What additional actions need to be taken in the future? _____
_____

Has the employee returned to work? _____

If yes, what date? _____ Regular Duty___ Light Duty___

This accident must be reported to Safety and Security. Has the employee contacted Safety and Security? ___Y ___N

IMMEDIATE SUPERVISOR'S SIGNATURE: _____ DATE: _____