EMPLOYEE ACCIDENT REPORT
Part 1: Employee Accident and Investigation Report

1. Employee Name _____
2. Employee Social Security Number (last four digits) _____
3. Address _____
4. Home Telephone _____
5. Campus Job Title _____
6. Date of Birth _____
7. Date of Accident _____
8. Time of Accident _____
9. Place of Accident _____
10. Employee's Work Location _____
11. Shift _____ 12. Pass Days _____
13. Employee Remained on Duty ( ) Yes ( ) No
14. Employee Required Medical Attention ( ) Yes ( ) No
15. Statement of Employee: _____

_____

_____

_____

16. Signature of Employee _____ 17. Date _____
18. Names of Eyewitness with Statement: _____

_____

_____

_____

19. Supervisor's Statement: _____

_____

_____

20. Supervisor's Signature _____ 21. Date _____
22. Date Employee First Absent _____

CS-13
C2128-681

STATE UNIVERSITY OF NEW YORK
REPORT OF ACCIDENT OR INJURY
(OTHER THAN A MOTOR VEHICLE ACCIDENT)

To be completed by Safety Supervisor

1. Campus: 28 ___ ___
2. Date and time of accident: Mo. Day Year Time
3. Date of report: Mo. Day Year
4. File ID: Year No. Sequence

5. Did accident involve personal injury: ○ A) Yes ○ B) No

6. Victim status: ○A) Student ○B) Faculty/Staff ○C) Patrol Officer ○D) FSA ○E) Patient ○F) Vendor ○G) Visitor ○H) Other (specify _____)

7. Name of office/department where employee is regularly assigned: _____

8. Sex: ○A) Female ○B) Male

9. Date of birth: Mo. Day Year

10. Name of victim (PRINT LAST NAME, FIRST, MIDDLE)

11. Marital status: ○A)Single ○B) Married ○C) Separated ○D) Divorced ○E) Unknown

12. Social Security Number: X X X X X

Local address: _____

13. Job title and grade:

Tel. _____

Home Address: _____

14. Employment date: Mo. Day Year

15. Was victim in authorized area: ○A) yes ○B) No ○C) Unknown

Tel: _____

16. Reporter of accident: ○ A) Faculty/Staff ○ B) Victim ○ C) Other (specify) _____

17. Name of reporter of accident: (PRINT LAST NAME, FIRST, MIDDLE)

18. General area of occurrence: ○A) Dorm ○B) Dining hall ○C) Student union ○D) Academic ○E) Gym ○F) Admin. ○G) Maint. Bldg. ○H) Road ○I) Parking Lot ○J) Grounds ○K) Hospital ○L) Other _____

Address: _____

19. Specific area of occurrence: Room:

Tel: _____

20. If physical injury, part of body injured: (ONE ONLY, MOST SERIOUS)

□A) Abdomen □B) Ankle □C) Arm □D) Back □E) Chest □F) Elbow □G) Eye □H) Face □I) Finger □J) Foot □K) Hand □L) Head □M) Hip □N) Knee □O) Leg □P) Lip □Q) Neck □R) Nose □S) Shoulder □T) Spine □U) Teeth □V) Thigh □W) Toes □X) Trunk □Y) Wrist □Z) Other (specify) _____

21. If physical injury, type of injury: (SELECT ONE ONLY)

○ A) Abrasion ○ B) Amputation ○ C) Bruise ○ D) Burn ○ E) Burn (chem.) ○F) Concussion ○G) Cut ○H) Dislocation ○I) Fracture ○J) Laceration ○K) Puncture ○L) Swelling ○M Tooth (broken) _____ ○N) Sprain _____ ○O) Strain ○P) Other (specify)

22. If physical injury, extent: ○A) Fatal ○B) Major ○C) Minor

23. If physical injury, nature: ○ A) Temporary ○ B) Permanent

24. Accident ○A) Athletic ○B) Academic ○C) Job related ○D) Other _____

25. Were safeguards provided: ○ A) Yes ○ B) No

26. Were safeguards in use: ○ A) Yes ○ B) No.

27. Are there witnesses: (List in narrative) ○A) Yes ○B) No

28. Medical assistance rendered: ○A) First aid by staff ○B) Infirmary ○C) Hospital ○D) Ambulance ○E) Other _____

29. Name and address of physician:

30. Name and address of hospital:

31. Has employee returned to work: ○A) yes ○B) No If yes, date: Mo. Day Year

32. Employee have restricted duties: ○ A) Yes ○ B) No

33. Supervisor notified: ○A) Yes ○B) No Date and time: Mo. Day Year Time

34. Name of Supervisor: _____

NARRATIVE: (Only give a brief description of who, what, when, where, how, etc.) List witnesses names and addresses.

Report completed by:	Title:	Date:
Safety Supervisor's signature:	Title:	Date: