EMPLOYEE INJURY/ACCIDENT REPORT FORM
Return to Human Resources Attention: Bonnie Gunn

Name: _____ Home Address: _____

Supervisor: _____ _____

Job Title: _____ Sex: M ☐; F ☐ Phone Number _____

Time Injury occurred: Hour _____ A.M. _____ P.M. Date of Injury: _____

Place of Injury: Hillsboro Campus ☐ Cleburne Campus ☐ Burleson Center ☐ Glen Rose Center ☐ Elsewhere ☐_____

TYPE OF INJURY

- ☐ Abrasion
- ☐ Bite
- ☐ Contusion (Bruise)
- ☐ Burn
- ☐ Concussion
- ☐ Cut
- ☐ Dislocation
- ☐ Fracture
- ☐ Laceration
- ☐ Poisoning
- ☐ Puncture
- ☐ Scalds
- ☐ Scratches
- ☐ Shock (el.)
- ☐ Sprain
- ☐ Other (specify) _____

BODY PART AFFECTED

- ☐ Abdomen
- ☐ Ankle
- ☐ Arm
- ☐ Back
- ☐ Chest
- ☐ Ear
- ☐ Elbow
- ☐ Face
- ☐ Foot
- ☐ Hand
- ☐ Head
- ☐ Knee
- ☐ Leg
- ☐ Mouth
- ☐ Scalp
- ☐ Wrist
- ☐ Other (specify) _____

CAUSE OF INJURY

- ☐ Chemicals
- ☐ Hot Objects
- ☐ Cut/Scrape by Glass
- ☐ Cut/Scrape by Power Tool
- ☐ Dust/Gases/Fumes/Vapors
- ☐ Object being lifted
- ☐ Collapsing Materials
- ☐ Fall/Slip: Level Ground
- ☐ Fall/Slip: Ladder
- ☐ Fall/Slip From Liquid
- ☐ Fall/Slip: Same Level
- ☐ Fall on Ice or Snow
- ☐ Fall/Slip/Trip: Misc.
- ☐ Fall/Slip: on Stairs
- ☐ Slipped But Did Not Fall
- ☐ Collision: Fixed Object
- ☐ Motor Vehicle: Misc
- ☐ Strain: Push or Pulling.
- ☐ Strain: Miscellaneous
- ☐ Strain: Repetitive Motion
- ☐ Strain: Lifting
- ☐ Strain: Using Tool/Mach.
- ☐ Strain: Reaching
- ☐ Strain: Hold or Carry
- ☐ Stepping on Sharpe Object
- ☐ Animal or Insect
- ☐ Explosion or Flare Back
- ☐ Foreign Matter in Eyes
- ☐ Inhaled/Ingested
- ☐ Struck: Falling Object
- ☐ Struck: Fellow Worker
- ☐ Struck: Tools
- ☐ Struck: Vehicle
- ☐ Struck: Object Lifted
- ☐ Struck:: Miscellaneous
- ☐ Contact: Electric Current
- ☐ Fire or Flame
- ☐ Welding Operations
- ☐ Cumulative (All Other)
- ☐ Other: Miscellaneous

Please Provide a Brief Description of the Accident:

(What were you doing? Where did it occur? What were conditions/environment like when it occurred)

Degree of Injury: ☐ Death ☐ Permanent Impairment ☐ Temporary (lost time) ☐ Non-Disabling (no lost time)

Department or Location where injury occurred: _____

List all equipment, material or chemicals employee was using when injury occurred:_____

Specify activity the employee was engaged in when the injury occurred:_____

Work Process that the employee was engaged in when the injury occurred:_____

Were safeguards or safety equipment Provided? ☐ Yes ☐ No Were they used? ☐ Yes ☐ No

Treatment Information

Initial Treatment:

- ☐ No Medical Treatment
- ☐ Minor by Employer
- ☐ Minor Clinic/Hospital
- ☐ Emergency Care
- ☐ Hospitalized (24 hours)

Physician Name (Last, First, MI): _____

Physician Street Address:_____

Physician City, State, ZIP:_____

_____

Hospital:_____

Hospital Street Address:_____

Hospital City, State, Zip:_____

Witnesses

Please list all Witnesses at the Scene of the Injury.

Name	*Phone Number*	*Address*

Remarks

(What recommendations do you have for preventing other injuries of this type?)

My signature here indicates that the information contained in this report to be true and correct.

Employee Signature:_____ Date:_____

For Office Use Only

Received by: _____

Employee Date of Birth: _____

Employee Social Security Number: _____

Employee Hire Date: _____

Employment Status: _____

Pay Rate: _____, per _____

Gross Amount of Last Paycheck: _____

Type of Claim:_____

Time Employee Clocked in for Work: _____

Last Work Date: _____

Date Human Resources was Notified: _____

Date Returned to Work: _____