Washington College
Office of Human Resources
300 Washington Avenue
Chestertown, MD 21620

Telephone: (410) 778.7799
Fax: (410) 778.7254

REPORT OF INJURY OR ACCIDENT:
Must be completed on the date of injury or accident and forwarded to the Office of Human Resources within 24 hours

To Be Completed By Injured Employee: **PLEASE PRINT**

1. Employee Name:____SS#:________________________________

2. Street Address:__________________________________City_________________State__________Zip___________

3. Home Phone #_____________________ Cell #_______________________ Date of Birth_________________________

4. Date of Injury or Accident_____________________ Time__________ a.m. / p.m. Check if Cannot Be Determined ☐

5. When did you first report this injury or accident: Date____________________ Time__________ a.m. / p.m.

6. To whom did you report this injury or accident:____

7. How did you report this injury or accident (verbal, telephone call, left message):_________________________________
____

8. Describe what you were doing when you were injured: ____
____
____
____

9. Describe the type injury or accident. (cut, scrape, bruise, sprain, break, etc) Be specific. _________________________
____
____
____

10. What part(s) of the body were affected by the injury or accident? Be specific. (left/right/hands/leg/foot/neck, etc.)_____
____
____
____

11. Did you finish work the day of the injury or accident? ______________ Yes __________ No

12. If yes were you able to perform the essential functions of your position or were you on modified duties?______________
____

13. Did you receive medical treatment? __________ Yes __________ No.

14. Describe any medical treatment you have received or are scheduled to receive. _________________________________
____

15. Who provided the medical treatment? Provide the name and address or the individual/facility where you received treatment____
____
____

I certify that the information I have provided above is true and correct to the best of my knowledge and belief. I also understand that if I answered "no" to item #13, and I seek medical treatment at a later date, that I will notify the Office of Human Resources immediately. I also understand that I will provide the Office of Human Resources with a copy of all medical reports related to the injury or accident described herein.

Employee Signature____ Date_____________________________

SUPERVISORS REPORT OF INJURY OR ACCIDENT:
Must be completed on the date of injury or accident and forwarded to the Office of Human Resources.

To Be Completed By Supervisor of the Injured Employee: **PLEASE PRINT**

1. Injured Employee Name:_______________________________________Position_____________________________

2. Date of Injury or Accident_____________________ Time__________ a.m. / p.m. Check if Cannot Be Determined ☐

3. When did you first learn of this injury or accident: Date__________________ Time__________ a.m. / p.m.

4. Who reported this injury or accident to you and how did they report it to you: (verbal, telephone call, left message):_____
____

5. Describe in detail what the employee reported to you they were doing when injured: ______________________________
____
____
____

6. Describe in detail what the employee reported to you as the type injury or accident. (cut, scrape, bruise, sprain, break, etc) Be specific. ____
____
____

7. What part(s) of the body did the employee complain were affected by the injury or accident? Be specific. (left/right/hands/leg/foot/neck, etc.)____
____
____

8. Identify the name(s) of witnesses to this injury or accident____
____

9. Did you speak with any of the witnesses? If so, identify who you spoke with specifically__________________________
____

10. Describe where the injury or accident occurred (specific physical location – department, office, parking lot, steps, etc.) __
____

11. Did the employee finish work the day of the injury or accident? ______________ Yes __________ No

12. If yes were they able to perform the essential functions of their position or were they on modified duties?_____________
____

13. Did the employee receive medical treatment? _________ Yes __________ No.

14. Describe any medical treatment the injured employee received or is scheduled to receive. ________________________
____
____

Additional Supervisor Comments:

____
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I certify that the information I have provided above is true and correct to the best of my knowledge and belief. I also understand that if I answered "no" to item #13 and the employee seeks medical treatment at a later date, that I will notify the Office of Human Resources immediately.

Supervisor's Signature____ Date____________________________

Department Director Signature_______________________________________ Date____________________________