WASHINGTON COLLEGE

**REPORT OF INJURY OR ACCIDENT:**

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

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

*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:

*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_____