The Office of People, Culture, and Talent
Risk Management Department

EMPLOYEE STATEMENT OF ACCIDENT

Instructions: Fill out completely and submit this form to the Risk Management Department (ext. 6428).

Employee Name: ______________________________ Date of Birth: ____________ Date of hire: ____________

Please check one: ☐ Administrator ☐ Faculty ☐ Classified ☐ CMS ☐ Hourly ☐ Reg.Volunteer

Job Title:_________________________ Dept./Div.:____________________ ID(900#): ____________________

Address: ______________________________ City: ___________________ State:______ Zip: ______________

Cell: ( ) ______- _______ Ext: _______ Date of Accident: _________ Time of Accident: _____ ☐a.m. ☐p.m.

Location where accident occurred (if not an AVC location, provide name of location & address; include room number or other description): ____

____

Witness(es) to the accident? ☐ Yes ☐ No if yes, name(s)____

Description of how accident occurred: ____

____

____

Part of body affected (i.e. back, left wrist, right eye, etc.)?: ____

____

Pre-designated physician on file in The Office of PCT? ☐ Yes ☐ No If yes: Name, address, and phone number of pre-designated physician?: ____

____

Time you began work on the day of the accident?________________ ☐ a.m. ☐ p.m.

What is your regular schedule? ☐ M ☐ T ☐ W ☐ TH ☐ F Hours per Day/Week: _______/________

Name of your immediate supervisor: ______________________________________

How could the accident have been prevented?____

____

Employee signature: _______________________________________ Date: _________________

FOR RISK MANAGEMENT USE ONLY- Please do not complete this area.

Employee Missed at least one full day of work after the injury? [ ] Yes [ ] No Date last worked: _____/_____/ ______

Date returned to work: _____/_____/ _______ RM Rep Initials: ______________ Date: ________________

REV 12/11/2024

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Additional comments: