ANTELOPE VALLEY COLLEGE

Department of Human Resources – Office of Risk Management

Please check one:
- ☐ Administrator
- ☐ Faculty F/T
- ☐ Faculty P/T
- ☐ Classified
- ☐ CMS
- ☐ Hourly
- ☐ Registered
- ☐ Volunteer

EMPLOYEE STATEMENT OF ACCIDENT

Please Print

Employee Name: _____ Date of Birth:____/____/____

Address: _____ Phone #: ( )_____-_____

City: _____ State:_____ Zip:_____ Date of Hire:____/____/__

District extension:_____ **Date of Accident**: _____ Time of Accident:_____ a.m.☐ p.m.☐

Job Title:_____ Department/Division:_____

Specific point at 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 HR? Yes☐ No☐

Name, address, and phone number of pre-designated physician?_____

_____

Tme you began work on the day of the accident?_____ a.m.☐ p.m.☐

What is your regular work schedule? M☐ T☐ W☐ TH☐ F☐ Hours work per day:___

Hours work per week:_____ Social Security #:_____

Missed at least one full day of work after the injury? (Risk Mgmt will complete when known) Yes☐ No☐

Date last worked?____/____/____ (Risk Mgmt will complete when known)

Date returned to work? ____/____/____ (Risk Mgmt will complete when known)

Name of your immediate supervisor: _____

How could the accident have been prevented?_____

Employee signature: _____ Date:____/____/____

Additional comments:
Page 2.