ANTELOPE VALLEY COLLEGE

DEPARTMENT OF HUMAN RESOURCES – OFFICE OF RISK MANAGEMENT

Supervisor's Report of Injury
Employee

Please Print

Employee Name:_____ Department/Division:_____

Job Title :_____ Date of Injury:____/____/___

Time of Injury:_____ a.m. p.m. On premises? Yes____ No_____

Time employee began work on the day of the accident?_____ a.m. p.m.

What is employee's regular work schedule? M T W TH F Hours work per day?_____

Hours work per week?_____ Did supervisor witness the accident? Yes_____ / No_____

Name(s) of witnesses:_____

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

_____

Description of how accident occurred: _____

_____

_____

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

_____

Did employee go to the doctor? Y N Did an unsafe condition contribute to the accident: Y N

Did the employee commit an unsafe act? Y N If yes, explain:_____

_____

_____

How could the accident have been prevented? _____

_____

_____

Supervisor: _____ Date:_____/_____/_____

Title: _____ Supervisor's Signature: _____

Additional comments: