ANTELOPE VALLEY COLLEGE

DEPARTMENT OF HUMAN RESOURCES – OFFICE OF RISK MANAGEMENT

Supervisor's Report of Injury
Student Workers/Students in Clinical Rotation

Please Print

Student's Name:_____ Department:_____

Student's Title:_____ Date of Injury:____/___/____

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

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

What is student's regular work schedule? (circle) M T W TH F Hours work per day?_____

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

Name(s) of witnesses:_____

Location where accident occurred (if different than AVC, provide name of location & address:) _____

_____

Description of how accident occurred: _____

_____

_____

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

_____

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

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

_____

_____

How could the accident have been prevented? _____

_____

_____

Supervisor: _____ Date:_____/___/_____

Title: _____

Additional comments:

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