

EMPLOYEE ACCIDENT REPORT
Part 1: Employee Accident and Investigation Report

1. Employee Name _____
2. Employee SSN (last four digits)_____ 3. Date of Birth _____
4. Address _____
5. Home Telephone _____
6. Campus Job Title _____
7. Date of Accident _____ 8. Time of Accident _____
9. Place of Accident _____
10. Employee's Work Location _____
11. Shift Hours _____ 12. Pass Days _____
13. Employee Remained on Duty () Yes () No
14. Employee Required Medical Attention () Yes () No
Type: First Aid Ambulance Walk-In Primary Care Emergency Room
Required: X-Rays Prescription Physical Therapy Other _____
15. Statement of Employee: _____

16. Signature of Employee _____ 17. Date _____
18. Names of Eyewitness with Statement: _____

19. Supervisor's Statement: _____

20. Supervisor's Signature _____ 21. Date _____
22. Date Employee First Absent _____

STATE UNIVERSITY OF NEW YORK
REPORT OF ACCIDENT OR INJURY
(OTHER THAN A MOTOR VEHICLE ACCIDENT)

CS-13
 C2128-681

To be completed by Safety Supervisor
 4. File ID: _____ Year No. Sequence

1. Campus: 28 _____	2. Date and time of accident: Mo. Day Year Time	3. Date of report: Mo. Day Year	
5. Did accident involve personal injury: A) Yes B) No		6. Victim status: A) Student C) Patrol Officer E) Patient G) Visitor B) Faculty/Staff D) FSA F) Vendor H) Other (specify _____)	

7. Name of office/department where employee is regularly assigned: _____

8. Sex: A) Female B) Male	9. Date of birth: Mo. Day Year	10. Name of victim (PRINT LAST NAME, FIRST, MIDDLE) _____
11. Marital status: A) Single C) Separated E) Unknown B) Married D) Divorced		Local address: _____ Tel: _____
12. Social Security Number: X X X X X X		
13. Job title and grade: _____		Home Address: _____ Tel: _____
14. Employment date: Mo. Day Year	15. Was victim in authorized area: A) yes B) No C) Unknown	

16. Reporter of accident:
A) Faculty/Staff B) Victim C) Other (specify _____)

17. Name of reporter of accident: (PRINT LAST NAME, FIRST, MIDDLE)

18. General area of occurrence: A) Dorm B) Dining hall C) Student union D) Academic E) Gym F) Admin. G) Maint. Bldg. H) Road I) Parking Lot J) Grounds K) Hospital L) Other _____	Address: _____ Tel: _____
19. Specific area of occurrence: _____ Room: _____	

20. If physical injury, part of body injured: (ONE ONLY, MOST SERIOUS) A) Abdomen F) Elbow K) Hand P) Lip U) Teeth Z) Other (specify) B) Ankle G) Eye L) Head Q) Neck V) Thigh C) Arm H) Face M) Hip R) Nose W) Toes D) Back I) Finger N) Knee S) Shoulder X) Trunk E) Chest J) Foot O) Leg T) Spine Y) Wrist	21. If physical injury, type of injury: (SELECT ONE ONLY) A) Abrasion F) Concussion K) Puncture P) Other (specify) B) Amputation G) Cut L) Swelling C) Bruise H) Dislocation M) Tooth (broken) D) Burn I) Fracture N) Sprain E) Burn (chem.) J) Laceration O) Strain
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22. If physical injury, extent: A) Fatal B) Major C) Minor	23. If physical injury, nature: A) Temporary B) Permanent	24. Accident A) Athletic C) Job related B) Academic D) Other _____
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25. Were safeguards provided: A) Yes B) No	26. Were safeguards in use: A) Yes B) No
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27. Are there witnesses: (List in narrative) A) Yes B) No	28. Medical assistance rendered: A) First aid by staff B) Infirmary C) Hospital D) Ambulance E) Other _____		
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29. Name and address of physician: _____	30. Name and address of hospital: _____
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31. Has employee returned to work: A) yes B) No If yes, date: Mo. Day Year	32. Employee have restricted duties: A) Yes B) No
33. Supervisor notified: A) Yes B) No Date and time: Mo. Day Year Time	34. Name of Supervisor: _____

NARRATIVE: (Only give a brief description of who, what, when, where, how, etc.) List witnesses names and addresses.

Report completed by: _____	Title: _____	Date: _____
Safety Supervisor's signature: _____	Title: _____	Date: _____