Coahoma Community College

EMPLOYEE ACCIDENT/INJURY INFORMATION FORM

NAME OF EMPLOYEE:

PLACE OF ACCIDENT:

DATE OF ACCIDENT/INJURY:

WHEN DID SUPERVISOR KNOW OF ACCIDENT/INJURY?

NAME OF SUPERVISOR:

DESCRIBE ACCIDENT/INJURY IN DETAIL

WHAT BODY PART WAS INJURED AND TO WHAT EXTENT WAS THE INJURY?

DESCRIBE WHAT YOU WERE DOING, WHERE YOU WERE, WHO ELSE WAS INVOLVED, WHAT HAPPENED, WHY IT HAPPENED AND WHAT CAUSED THE INJURY:

WITNESS (ES):

EMPLOYEE'S SIGNATURE:

Employee: You must complete this form and give it to your supervisor. Report to the Nurse's Station to receive treatment prior to going to a physician or hospital emergency room.

Supervisor: Complete the supervisor's section on page 2, make a copy for the department file and make sure the original copy of this form is forwarded to the Human Resources Office within 24 hours or the next working day.

SUPERVISOR/SAFETY OFFICER'S INVESTIGATION REPORT

EMPLOYEE'S NAME:

DEPARTMENT: _____ **SHIFT:**

POSITION: _____ **HOW LONG ON THIS JOB?**

DID EMPLOYEE GO FOR MEDICAL TREATMENT OFF CAMPUS? ☐ **YES** ☐ **NO**

Describe body parts injured and extent of injury:

Describe in detail what employee was doing when injury occurred, how/why the accident happened and what directly injured the employee:

SUPERVISOR: _____ **DATE:**

What can be done to prevent this type accident in the future?

What action has been taken or is recommended to be taken and how will it help prevent similar accidents and/or improve operations?

SAFETY INVESTIGATOR _____ **DATE**