College of the Holy Cross/Human Resources

Accident Information Report

Employee name: ______________________

Address: ______________________________________

City: __________________________ State: ________ Zip:

Phone: ______________ Date of hire: ____________

Sex: (circle one) Male Female Status : (circle one) Married Single

Department: __________________ Position: __________________________

Supervisor's name: ________________________________

Normal shift hours from _____ am/pm *to* _____ am/pm

Normal work days:(please circle) M T W TH F S SU

Date of accident: ______________ Location of accident: __________________

Estimated time of accident: ____________ am/pm

Date supervised notified: ___________ Employee treated at Health Services? Yes No

Nature and location of injury:

Witnesses or other parties involved (if any):

Full description of the cause of injury:

If treated elsewhere, name and address of physician and/or hospital:

First lost day of work: _________ Restricted duty from *to*

Employee returned to work? Yes No If yes, date & hour: ____________________

____________________________ date of this report

____________________________ employee signature

Revised 12/5/2013