EE ID: __________ WC#: ___________

# Augusta University
# Employee's Report of Accident/Injury

**Section A: To be completed by Employee**

1. Employee's Name: ______________________________________________
(Last) (First) (Middle)

2. Home Address: ______________________________________________

3. Employee SSN: ____________________ 4. Home Phone No: ____________________

5. Date of Birth: ______________ 6. Male □ Female □ 7. Marital Status: ______________

8. Height: ____________ 9. Weight: ____________ 10. Dominant Hand: Right □ Left □

10. Employee's Hobbies: ______________________________________________

11. Number of dependents under age 18: ________ 12. Military Service? ______ 13. Branch: ________

14. Job Title: ________________________ 15. Dept Name/Dept: ____________________

**ACCIDENT INFORMATION**

16. Date of Accident: __________________ 17. Time of Accident: ____________A.M. P.M.

18. Location of Accident (Be specific, include room no, bldg, floor, etc :) ____________________

19. Time the work day began on the day of the accident: ________________________A.M. P.M.

20. Type of Injury (burn, needle stick, exposure, etc.) ______________________________
(List which finger, hand, part of body, etc.)

21. Describe the circumstances involved in this accident/injury (be sure to state the job related duty you were performing at the time of accident): ______________________________________________

______________________________________________

______________________________________________

TREATMENT INFORMATION

22. Were you treated: YES NO (circle one) If "yes", where? ____________________________

23. Condition: ____________________ 24. Were medications given/prescribed? ____________

25. Witnesses to accident: Name ____________________________ AU Ext: __________
Name ____________________________ AU Ext: __________

26. Primary Care Physician Name and Number: ____________________________________

________________________________ ________________________________
(Employee's Signature) (Signature of Immediate Supervisor)

## Section B: To be completed by Supervisor

1. Date notified of injury: ______________________ 2. Date of injury: ______________________

3. Supervisor Name: ___________________________ 4. Supervisor Office phone # _____________

5. Name of Injured Employee: _________________________________________________________

6. Date of hire: ________________ 7. Full Time □ Part Time □

8. Shift/Hours Employee works: _______________________________________________________

9. Has the employee returned to work? ________________ If "yes"-Date: ____________Time:________

10. Was the claim reported late? _________ If "yes," why? _________________________________

11. Any prior injuries (if yes, list)? ____________________________________________________

12. Any prior health conditions (if yes, list)? ____________________________________________

13. Prior medications (if yes, list)? ____________________________________________________

14. After review of all facts, what was the hazardous condition, unsafe work practice or other root cause of the accident/injury? __________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

15. What is recommended to prevent this type of accident/injury from occurring again? ___________

_____________________________________________________________________________________

_____________________________________________________________________________________

16. Actions taken to ensure recommendations are considered (to include education): _______________

_____________________________________________________________________________________

_____________________________________________________________________________________

Signature of Supervisor: ___________________________________ Date: _____________________

- **Please send a copy of employee's job description with form.**

*Important: Employee must complete the Leave Election Form *

NOTE: Complete and return both pages to Human Resources, Benefits and Data Management, Annex Building, Room 1121 or fax to 706-721-1996 within 5 working days of accident/injury.