The State University of New York System Administration

Employee Accident Report

1	EMPLOYEE NAME		
2	EMPLOYEE ADDRESS		
3	HOME TELEPHONE	4 DATE OF BIRTH	GENDER ☐ Male ☐ Female
5	DATE OF EMPLOYMENT		
6	CURRENT JOB TITLE		BARGAINING UNIT
7	SHIFT	PASS DAYS	☐ Full-Time ☐ Part-Time
8	EMPLOYEE'S WORK LOCATION	OFFICE TELEPHONE	
9	DATE OF ACCIDENT	TIME OF ACCIDENT	☐ AM ☐ PM
10	PLACE OF ACCIDENT		
11	NATURE OF INJURY AND PART(S) OF BODY AFFECTED		
12	EMPLOYEE REMAINED ON DUTY ☐ Yes ☐ No	IF NO, DATE OF FIRST DAY OF ABSENCE	
	HAS EMPLOYEE RETURNED TO WORK? ☐ Yes ☐ No	IF YES, DATE OF RETURN	
13	EMPLOYEE REQUIRED MEDICAL ATTENTION? ☐ Yes ☐ No	IF YES, DATE OF MEDICAL ATTENTION	
	NAME AND ADDRESS OF DOCTOR/HOSPITAL		
14	WHAT WAS THE EMPLOYEE DOING WHEN INJURED? (IDENTIFY TOOLS, EQUIPMENT OR MATERIAL THAT WERE BEING USED)		
15	HOW DID ACCIDENT OR EXPOSURE OCCUR? (DESCRIBE THE EVENTS THAT RESULTED IN INJURY OR OCCUPATIONAL EXPOSURE. TELL WHAT HAPPENED AND HOW IT HAPPENED.)		
16	OBJECT OR SUBSTANCE THAT CAUSED INJURY (e.g. MACHINE THEY STRUCK AGAINST OR WHICH STRUCK THEM; VAPOR OR SUBSTANCE INHALED OR SWALLOWED; CHEMICAL IRRITATING SKIN, ETC.) FOR STRAINS, OBJECTS BEING LIFTED, PULLED, ETC.		
17	NAMES OF ANY EYEWITNESSES		
18	PERSON COMPLETING REPORT	SIGNATURE	DATE
19	SUPERVISOR'S STATEMENT (INCLUDE DATE SUPERVISOR FIRST KNEW OF INJURY)		
20	SUPERVISOR'S SIGNATURE		DATE

Directions for Completing Report

Please print carefully. Attach additional sheets if necessary.

This report is to be completed by employee (or supervisor, in absence of injured employee) immediately upon occurrence of an on-the-job accident or an occupational illness. The original copy of this completed report is to be returned to the Office of Human Resources.

1. Employee's name.
2. Employee's mailing address.
3. Employee's telephone number.
4. Employee's date of birth and gender.
5. Employee's date of hire.
6. Employee's job title and bargaining unit.
7. Employee's normal shift (specify hours) and pass days (days employee is off duty). Indicate if employee works full-time or part-time.
8. Employee's campus address and campus phone number.
9. Date and time employee was injured.
10. Building, floor, unit or other information to indicate where accident occurred.
11. Indicate exactly what the injury is and what body part(s) were affected (i.e. sprain to right ankle, cut to left forearm, cuts to knees, etc.).
12. This item must be checked after determining if employee was able to remain at the normal work station. If employee loses time as a direct result of this injury or illness, indicate first day of absence. If known, indicate if injured employee has returned to work and the date of return.
13. Check if employee required medical attention either immediately after accident or at a subsequent date. If unknown, check no. If yes, indicate name and address of doctor and/or hospital and date medical attention was received.
14. Identify tools, equipment or material employee was using and what he/she was actually doing at the time of injury or illness. Be specific.
15. Fully describe the events that resulted from the injury or exposure. Specifically explain what happened and how it happened. Mention particular objects, unsafe conditions or other factors that contributed to the injury or illness.
16. Indicate machine or tool employee struck against or which struck employee; vapor or substance inhaled or swallowed; chemical that irritated the skin, etc. For strains, indicate what was being lifted, pulled, etc.
17. Names of eyewitnesses.
18. Name and signature of person completing report and date signed.
19. Supervisor's description of any condition that may exist or other relevant information concerning the accident.
20. Supervisor's signature and date signed.