



# ACCIDENT REPORT FORM

TO: HUMAN RESOURCES

Employee Name (Print) \_\_\_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date of Hire \_\_\_\_\_ Time Began Work \_\_\_\_\_ Rate of Pay \_\_\_\_\_

Department \_\_\_\_\_ Position \_\_\_\_\_

Supervisor's Name \_\_\_\_\_ When Was Supervisor Notified? \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_

Where did it happen? \_\_\_\_\_

Address \_\_\_\_\_

What was employee doing when the accident occurred (provide explanation of accident)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Witness(es) \_\_\_\_\_

Address(es) \_\_\_\_\_

Phone \_\_\_\_\_

Nature of injury and part(s) of body affected (e.g., sprained middle finger of left hand): \_\_\_\_\_

\_\_\_\_\_

Was medical care provided?  Yes  No

If no, why \_\_\_\_\_

If yes, give name of physician or clinic/hospital \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**\*\*Provide Report from Doctor or Clinic\*\***

Date disability began, if any \_\_\_\_\_

What do you recommend to do to prevent a reoccurrence of this accident and accidents due to same cause or causes? \_\_\_\_\_

\_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

---

**EMPLOYER SECTION:**

First Report Date \_\_\_\_\_ Policy Number \_\_\_\_\_

Contact Information: Teresa McPherson, HR Coordinator  
[tmcpherson@shorter.edu](mailto:tmcpherson@shorter.edu)  
(706) 233-7461