

Injured Person's Report of Accident

This form can be obtained online at www.findlay.edu

INSTRUCTIONS:

- Please print or type.
- Please sign and date the form and send it to the Office of Human Resources
- A Self-Insured Workers' Compensation Packet must be completed if you seek medical treatment.

Employer	Employer Address
Location - if different from mailing address	Date of Report

Injured Worker Name (first, M.I., last)	Age	Sex	ID #	Social Security #
Address	City	State	9-digit ZIP code	
Phone #	Occupation	Department		

Date of Accident/Illness	Time (designate a.m. or p.m.)
Place of treatment for injury/illness	Exact location of accident
Job or activity at time of accident	Were you working at the time of accident?
Supervisor at time of accident	Names of witnesses to accident
Name of person to whom injury was reported	Name and address of physician, if seen
Name and address of hospital, if hospitalized	

Report prepared by: _____ Position: _____

Description of Accident - In the space below, describe how your injury was sustained and state in detail what you were doing at the time and what you did immediately thereafter. Include details such as how the accident occurred, the specific body parts affected, what injured you: _____

Describe any unsafe acts: _____

Describe any unsafe conditions: _____

Injured Person Signature

Date