

ALVIN COMMUNITY COLLEGE
ACCIDENT REPORT FORM

The responsibility for reporting industrial accidents rests upon the immediate supervisor of the person injured and/or on the person in charge of the area/activity where the accident occurred. By definition, an industrial accident is one which occurs while an individual is performing the duties of his/her position. All other accidents should be reported by those who witness the accident and/or by the individual in charge of the area/activity in which it took place. The importance of reporting accidents promptly cannot be overemphasized because compensation entitlements and the legal and insurance interests of the college and individuals involved may be adversely affected by delays or failure to report.

EMPLOYEE INFORMATION (Print or Type)			TODAY'S DATE
NAME _____ (LAST) (FIRST) (M.I.)			SOCIAL SECURITY NUMBER
HOME PHONE (WITH AREA CODE)	CELL / ALT PHONE (WITH AREA CODE)	WORK PHONE (WITH AREA CODE)	DATE OF BIRTH
ADDRESS _____ (STREET) (CITY) (ZIP)			
POSITION TITLE / DEPARTMENT			IMMEDIATE SUPERVISOR

ACCIDENT INFORMATION (Print or Type)

ACCIDENT REPORTED BY	DATE OF ACCIDENT
ACCIDENT LOCATION (SPECIFY - BUILDING / HALLWAY / STAIRS)	TIME OF ACCIDENT
WITNESSES	
HOW AND WHY DID THE ACCIDENT / INJURY OCCUR:	WAS EMPLOYEE DOING REGULAR JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO
DESCRIBE THE INJURY / ILLNESS AND/OR SPECIFY PART OF BODY INJURED:	WAS PROTECTIVE EQUIPMENT BEING USED? <input type="checkbox"/> YES <input type="checkbox"/> NO
DESCRIBE THE PROTECTIVE EQUIPMENT AND/OR SAFETY PROCEDURE BEING USED / FOLLOWED:	IS THIS STANDARD DEPARTMENT EQUIPMENT AND/OR PROCEDURE? <input type="checkbox"/> YES <input type="checkbox"/> NO
WHAT PREVENTATIVE MEASURES COULD BE USED IN THE FUTURE TO AVOID SIMILAR ACCIDENTS?	

CARE / TREATMENT (Print or Type)

FIRST AID / SELF-ADMINISTERED CARE / EMERGENCY MEDICAL CARE PROVIDED BY:	ATTENDING PHYSICIAN (IF APPLICABLE):
ADDRESS OF TREATMENT PROVIDER IF OTHER THAN SELF:	DID EMPLOYEE REPORT TO WORK THE NEXT SCHEDULED WORK DAY? <input type="checkbox"/> YES <input type="checkbox"/> NO
	IF NOT, WHAT IS THE EXPECTED RETURN TO WORK DATE?

EMPLOYEE SIGNATURE: _____ DATE: _____
 SUPERVISOR SIGNATURE: _____ DATE: _____

RETURN THE COMPLETED FORM TO THE HUMAN RESOURCES OFFICE

SAFETY COMMITTEE INVESTIGATION / DOCUMENTATION

DATE OF INVESTIGATION

DETAILS OF INCIDENT

IS THERE A WRITTEN DEPARTMENTAL SAFETY PROCEDURE? WERE SAFETY GUIDELINES / PROCEDURES BEING FOLLOWED?

EMPLOYEES INTERVIEWED

INVESTIGATION CONDUCTED BY	NAME (PRINT)	NAME (PRINT)
	TITLE	TITLE
	SIGNATURE	SIGNATURE