

SOUTHSIDE VIRGINIA COMMUNITY COLLEGE

Accident Report Form

1. Employee Information

Injured Employee Name: _____

Employee Position/Title: _____

Campus/Work Site Where Accident Occurred:

2. Accident Details

Date of Accident (MM/DD/YYYY): _____

Time of Injury: AM PM

Accident Report Completed By: Injured Employee Supervisor

Date Reported to Supervisor (MM/DD/YYYY): _____

3. Injury Information

Body Part(s) Injured: _____

Nature of Injury: _____

4. Location and Conditions

Specific Location of Accident (Building, Room, Area):

Environment: Inside Outside Wet Dry

On Employer's Premises: Yes No

5. Description of Accident

In a concise paragraph, describe how the accident occurred:

6. Additional Comments

Additional Comments:

7. Witness Information

Witness 1 Name: _____

Witness 1 Status (Employee, Student, Visitor, etc.):

Witness 2 Name: _____

Witness 2 Status (Employee, Student, Visitor, etc.):

Witness 3 Name: _____

Witness 3 Status (Employee, Student, Visitor, etc.):

8. Report Preparation

Prepared By (Printed Name): _____

Title: _____

Date (MM/DD/YYYY): _____

Electronic Signatures

Employee/Preparer Signature: _____ Date: _____

Supervisor Signature (if applicable): _____ Date: _____

Upon completion, please submit this form to Human Resources for submission to the Workers' Compensation Carrier.