

EMPLOYEE'S REPORT OF ACCIDENT

UNIVERSITY OF CALIFORNIA AGRICULTURE AND NATURAL RESOURCES INJURY AND ILLNESS PREVENTION PROGRAM

Employee Information

Employee Name: _____ Home Telephone: _____
Title/Job Classification: _____ Work Telephone: _____
ANR Office/Location: _____
Employment Status: Full-Time Part-Time Career Temporary Seasonal Student Volunteer Other: _____
Name of Supervisor: _____ Telephone: _____

Accident Information

Date of Accident: _____ Time of Accident: _____
Date and Time Accident Reported: _____ To Whom? _____

Location where accident occurred (street address or building/room #):

Name and telephone number of witnesses:

Nature of Injury (list parts of body affected and type of injury, i.e.,; sprained right ankle):

What were you doing when the accident occurred?

Describe how the accident occurred:

What could be done to prevent this sort of accident in the future?

Medical Treatment Information

Did you receive medical treatment? Yes No If yes, date and time you sought medical attention: _____
Medical Care Provider Name: _____
Address: _____ Telephone: _____

Employee Signature: _____ Date: _____

Note: This form is intended for documentation of internal Research and Extension Center investigation of an accident, injury or illness. This is not a substitute for Workers' Compensation injury reporting forms. Please ensure all injuries or illnesses are promptly reported to the Regional Office and the appropriate Workers' Compensation office.