LOYOLA
UNIVERSITY MARYLAND

EMPLOYEE ACCIDENT AND INJURY REPORT
(TO BE COMPLETED BY EMPLOYEE)

1. Full Name: _____ Social Security # _____
2. Address: _____
3. Home Phone #: _____ Work Phone #: _____
4. Date of Birth (MM/DD/YY): _____ Job Title: _____
5. Hourly-Weekly Wage: _____ per _____ Date of Hire: _____
6. Usual Shift Hours: 7am - 3pm ☐ 3pm - 11 pm ☐ 11 pm - 7 am ☐ other ☐ Please specify: _____
7. Number of Dependents: _____

FACTS OF INCIDENT

8. Date & Time of Accident: _____ Day of Week: _____
9. Location of Incident (facility, dept. & floor): _____
10. Explain COMPLETEY in your own words exactly how the incident occurred. Include all specific details and any unusual conditions, which contributed to the incident. Detail what you were doing immediately prior to the occurrence:

11. Did anyone else witness this? If so, please provide name and phone#: _____
12. Were you performing within your normal duties? (Yes ☐ No ☐) If not, please explain:

13. Name any conditions, equipment, residents, etc. that contributed to the cause of the incident:

Were safety devices or equipment provided? (gloves, goggles, lifts, belts, etc.) _____

Were they used? (Yes ☐ No ☐) If not, Why?

NATURE OF INJURY

14. Describe in detail the nature and extent of your injury:

15. List any pre-existing conditions or prior injuries to the same body part:

16. Was first aid given? (Yes ☐ No ☐) If so, what kind?

17. Did you refuse medical treatment? (Yes ☐ No ☐) If so, why?

18. Name and Phone# of medical facility and physician:

Employee's Signature: _____ Date: _____

(This form is to be completed by employee immediately following incident and no later than the end of shift)

Print Form

Updated: 08/28/09