HOWARD COUNTY JUNIOR COLLEGE DISTRICT
INJURY REPORT

ALL ITEMS MUST BE THOROUGHLY COMPLETED BY THE EMPLOYEE. THE REPORT WILL NOT BE ACCEPTED IF NOT COMPLETE. IF NOT APPLICABLE, PLEASE PUT N/A. RETURN COMPLETED FORM TO THE HUMAN RESOURCES OFFICE IMMEDIATELY.

NAME OF EMPLOYEE: _____ SS #: _____

DEPT: _____ OCCUPATION: _____

HOME MAILING ADDRESS: _____ DATE OF BIRTH: _____

_____ MARITAL STATUS: _____

HOME PHONE #: _____ SPOUSE'S NAME: _____

NO. OF DEP. CHILDREN: _____

WORKSITE LOCATION OF INJURY: _____ (STAIRS, DOCK, BUILDING NAME, ETC.)

DATE REPORTED: _____

NAME OF PERSON REPORTED TO: _____

TREATING DOCTOR'S NAME: _____ DATE OF INJURY: _____

MAILING ADDRESS: _____

_____ TIME OF INJURY: _____

PHONE #: _____ NATURE OF INJURY (FALL, TOOL, MACHINE, ETC.): _____

PART OF BODY INJURED OR EXPOSED: _____

HOW AND WHY INJURY/ILLNESS OCCURRED: _____

WITNESSES: _____

WHEN THE ACCIDENT OCCURRED, WERE YOU DOING YOUR REGULAR JOB/WERE YOU ON DUTY? _____YES _____NO

IF NOT, PLEASE EXPLAIN _____

IF APPLICABLE, DATE LOST TIME BEGAN: _____

IF APPLICABLE, RETURN TO WORK DATE/OR EXPECTED: _____

LIST UNSAFE ACT, IF ANY: _____

LIST UNSAFE PHYSICAL OR MECHANICAL CONDITION, IF ANY: _____

LIST UNSAFE PERSONAL FACTOR, IF ANY: _____

LIST HAZARD CONTROLS DESIGNED TO PREVENT INJURY, IF IN EFFECT AT TIME OF INJURY: _____

PERSONAL PROTECTIVE EQUIPMENT BEING USED AT TIME OF ACCIDENT: _____

CORRECTIVE ACTION TAKEN OR RECOMMENDED TO SAFETY OFFICER: _____

TREATMENT DATA:
WAS INJURED TAKEN TO: [ ] HOSPITAL [ ] PERSONAL PHYSICIAN [ ] HOME

DIAGNOSIS AND TREATMENT, IF KNOWN: _____

INJURED EMPLOYEE'S SIGNATURE _____ DATE _____

SUPERVISOR'S SIGNATURE _____ DATE _____

(PLEASE INSURE ALL ITEMS ARE COMPLETED. PUT N/A IF NOT APPLICABLE.)