COLUMBIA UNIVERSITY HUMAN RESOURCES

Departmental Accident Report Form

for Workers' Compensation Benefits

Employee Information

To be completed by the employee

Last Name: _____ First Name: _____

Employee ID: _____ Date of Birth: __/__/____ Home Phone: (___) ___-____

Address: _____ Apt. #: _____

City, State, ZIP: _____

Employment Date: __/__/____ CU Department: _____ Occupation: _____

Work Phone: (___) ___-____ ☐ Part Time ☐ Full Time

Wages per week: $_____ Days per week worked: _____ Regular Days Off: _____

Accident Information

To be completed by the employee—all questions required

Date of injury/illness: __/__/____ Time of injury/illness: _____ Time you started work: _____

Location (building, room) where injury/illness occurred: _____

What were you doing when injury/illness occurred?: _____

How did the injury/illness occur?: _____

Was the injury caused by a sharp object (needle, scalpel, razor, etc.)? If so, you must specify the device type and brand: _____

Describe the object or substance (chemical, blood, etc.) which directly injured you: _____

Describe the injury/illness—indicate type of injury, specify left or right, and so on, for example, "upper right leg": _____

To whom did you report the accident?: _____ Date Reported: __/__/____ Time reported: _____

Witness's Name: _____ Witness's address: _____

Supervisor's Statement

To be completed by the supervisor

Was employee paid for the full day? ☐ Yes ☐ No Is employee losing time? ☐ Yes ☐ No

Employee's first day away from work: __/__/____ Has employee returned to work? ☐ Yes ☐ No

Is employee a union member? ☐ Yes ☐ No Expected date of return to work: __/__/____

Will the employee be paid for lost time? ☐ Yes ☐ No Did the injured employee receive medical attention? ☐ Yes ☐ No

Name and address of doctor or hospital where first treated: _____

Who investigated the accident? Name: _____ Title: _____

Work Phone: (___) ___-____ Fax: (___) ___-____

Supervisor's discussion with employee on HOW TO PREVENT THIS TYPE OF INJURY/ILLNESS: _____

Signatures

I CERTIFY THAT THE ACCIDENT INFORMATION PROVIDED ABOVE IS TRUE.

EMPLOYEE Signature: _____ Date *(mm/dd/yyyy):* _____

Supervisor's comments: _____

SUPERVISOR Signature: _____ Date *(mm/dd/yyyy):* _____