**Employee Notification of Workplace Accident**



H U M A N R ES O U R C ES

### To be completed immediately after a workplace accident for workers’ compensation benefits

### 

**Employee Information**

#### To be completed by the employee (if possible)

Last Name:

First Name:

UNI:

Best phone number to reach you: Employee Affiliation/Type:

* CU Employee
* RMFH
* State
* Contractor
* Visitor
* Temp Employee
* Volunteer

Did you tell your supervisor of the injury/illness? Yes No

Department: Job Title:

HR Departmental Contact (if known):

HR Departmental Contact email (if known):

# Accident Information

#### Please answer all questions

Date of injury/illness *(mm/dd/yyyy):* Time you started work: AM PM

Time of injury/illness:

AM  PM

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

How did the incident occur / what task were you engaged in at the time injury/illness began?

Please Select:

* + Abdomen
  + Ankle
  + Elbow
  + Disc (Back)
  + Fingers
  + Foot
  + Groin
  + Head
  + Knee
  + Lower Back
  + Multiple Body Parts
  + Neck Injury
  + No Physical Injury
  + Pelvis

**Type of Injury**

Please Select:

* Bite/ Scratch
* Bodily Reaction
* Caught in/ Under/ BTN
* Contact w/ Chemical
* Contact w/ Electrical
* Extreme Temperature
* Fall from Elevation
* Fall on the Same Level
* Motor Vehicle
* Needle Stick
* Overexertion
* Puncture
* Rubbed/ Abraded
* Slip/Trip
* Struck Against
* Struck By
* Other (describe below)
* Exposure

If Exposure, Select Type:

* Dermal (Skin)
* Injection
* Inhalation
* Ingestion

If other, please describe:

**Nature of Injury**

If the accident was caused by a needle, please list the type of needle (device brand/type):

Please Select:

* Abrasion
* Animal Bite or Scratch
* Burn
* Chemical Spill
* Chemical Exposure
* Contusion
* Crushed
* Foreign Body
* Fracture
* Illness/ Infection
* Laceration
* Needle Stick
* Puncture
* Rash
* Repetitive Motion
* Sprain/ Strain
* Struck By/ Against
* Other (specify below)

Lab Accident? Yes No

Description (if not above):

### Body Part

**Right Side Left Side**

Description (if not above):

**If you need help filling out this form, please ask your supervisor or human resources**

Were you seen in an emergency room? Yes No

Were you in contact with blood or bodily fluids? Yes

Were you harmed by a sharp object? Yes No

Were you hospitalized overnight as an inpatient? Yes No

No What object directly harmed you?

To whom did you report the accident? (Name):

Date reported (mm/dd/yyyy): Time reported: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness name (if known):

Witness’ email:

Witness' phone:

# Signature

**I CERTIFY THAT THE ACCIDENT INFORMATION PROVIDED ABOVE IS TRUE.**

**Completed by Employee Completed by Employer**

**If completed by employer, state your name and relationship to the employee:**

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

# Submitting Your Accident Report

This form is only complete after it has been submitted to Leave Management, Environmental Health and Safety, and either your HR Departmental contact or your Supervisor.

Please submit this form by scanning and sending it to [leavemanagement@columbia.edu](mailto:leavemanagement@columbia.edu) and [occusafety@columbia.edu](mailto:occusafety@columbia.edu)