EMPLOYEE REPORT of ACCIDENT/INJURY
Eastern North Carolina School for the Deaf

The employee must complete this report as soon as possible following an accident/injury. This report will be provided to the supervisor within 24 hours of the accident/injury.

Name: ______________________ **Date of Injury:** __________ **Time of Injury:** ________ **AM PM**

Social Security # __________ **Date of Birth:** ______ **Work Phone #** __________ **Home Phone #** __________

☐**Full Time** ☐**Part Time** **Date Employed:** ______ **Dept/Div:** ______________________

Home Address: ____

Shift: **1st** ☐ **2nd** ☐ **3rd** ☐ **Start Time of Work Day:** : **AM PM**

Witnesses (attach witness statement for each)

Name: ______________________ **Title:** __________ **Phone Number:** __________

Name: ______________________ **Title:** __________ **Phone Number:** __________

Name: ______________________ **Title:** __________ **Phone Number:** __________

Exact Location Injury Occurred: **Duties Being Performed:**

Describe the activity you were involved in at the time of injury:

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Choose factor (s), which directly or indirectly caused the accident to occur:

☐**Struck by Flying/Thrown Object**	☐**Caught in/Under/Between Objects**	☐**Temperature Extremes**
☐**A Fall**	☐**Struck by an Object/Person**	☐**Rubbed or Abraded by Object**
☐**Bodily Reaction**	☐**Electric Shock**	☐**Struck Against Object**
☐**Blood/Fluid Exposure**	☐**Other Disease Exposure**	☐**Noise Exposure**
☐**Vehicle/Equipment Accident**	☐**Toxic Material Exposure**	☐**Repetitive Motion**
☐**Client Caused**	☐**Client Attack**	☐**Other-Describe**

Nature of Injury:

☐**Head**	☐**Trunk**	☐**Digestive**	☐**Eye (s) R L B**	☐**Wrist(s) R L B**	☐**Ankle(S) R L B**
☐**Neck**	☐**Abdomen**	☐**Respiratory**	☐**Shoulder(s) R L B**	☐**Finger(s) T I M R P**	☐**Foot/Feet R L B**
☐**Chest**	☐**Groin**	☐**Circulatory**	☐**Arm (s) R L B**	☐**Hip(s) R L B**	☐**Toe(s) R L B**
☐**Back**	☐**Skin**	☐**Hand (s) R L B**		☐**Other-Describe:**	

Medical Treatment:

☐**No Treatment** ☐**First Aid** ☐**Urgent Care** ☐**Emergency Room**

Employee's Signature: ______________________ **Title:** __________ **Date:** ______

Supervisor's Signature: **Title:** **Date:**

Distribution:
DHHS S&B (08/22/07)

NOTE: Form must be typed and completed in full. After completion print off the form for signatures. Thank you….