

## REPORT OF INJURY OR ACCIDENT:

## Washington College

Office of Human Resources 300 Washington Avenue Chestertown, MD 21620

Telephone: (410) 778.7799 Fax: (410) 778.7254

Must be completed on the date of injury or accident and forwarded to the Office of Human Resources within 24 hours

To Be Completed By Injured Employee: PLEA	SE PRINT			
1. Employee Name:	SS#:			
2. Street Address:	City	Sta	iteZip	
3. Home Phone # Ce	11 #	Date of Bir	th	
4. Date of Injury or Accident	Time	a.m. / p.m. Cl	neck if Cannot Be Determined †	
5. When did you first report this injury or accide	ent: Date	Time	a.m. / p.m.	
6. To whom did you report this injury or acciden	nt:			
7. How did you report this injury or accident (ve	erbal, telephone call, le	eft message):		
8. Describe what you were doing when you were	e injured:			
9. Describe the type injury or accident. (cut, scr	ape, bruise, sprain, bre	eak, etc) Be specific		
10. What part(s) of the body were affected by the	ne injury or accident?	Be specific. (left/right	/hands/leg/foot/neck, etc.)	
11. Did you finish work the day of the injury or	accident?	Yes	No	
12. If yes were you able to perform the essential	functions of your posi	tion or were you on m	odified duties?	
13. Did you receive medical treatment?				
14. Describe any medical treatment you have rec				
15. Who provided the medical treatment? Provi treatment			cility where you received	
I certify that the information I have provided above is answered "no" to item #13, and I seek medical treatalso understand that I will provide the Office of Hudescribed herein.	ment at a later date, that	t I will notify the Office o	of Human Resources immediately.	
Employee Signature		Date		

## SUPERVISORS REPORT OF INJURY OR ACCIDENT:

Must be completed on the date of injury or accident and forwarded to the Office of Human Resources.

To Be Completed By Supervisor of the Injured Employee: PLEASE PRINT

1. Injured Employee Name:		Position	
Date of Injury or Accident	Time	a.m. / p.m. Check if Cannot	Be Determined †
3. When did you first learn of this injury or accide	ent: Date	Time a.ı	m. / p.m.
4. Who reported this injury or accident to you and	how did they report	it to you: (verbal, telephone call, le	eft message):
5. Describe in detail what the employee reported t	o you they were doin	ng when injured:	
6. Describe in detail what the employee reported to Be specific.			, sprain, break, etc)
7. What part(s) of the body did the employee com (left/right/hands/leg/foot/neck, etc.)			ic.
8. Identify the name(s) of witnesses to this injury			
9. Did you speak with any of the witnesses? If so	, identify who you sp	ooke with specifically	
10. Describe where the injury or accident occurred		•	•
11. Did the employee finish work the day of the in	njury or accident?	Yes	No
12. If yes were they able to perform the essential f	unctions of their posi	ition or were they on modified dutie	es?
13. Did the employee receive medical treatment?	Yes	No.	
14. Describe any medical treatment the injured en	nployee received or is	s scheduled to receive.	
Additional Supervisor Comments:			
I certify that the information I have provided above is answered "no" to item #13 and the employee seeks n immediately.			
Supervisor's Signature		Date	
Department Director Signature_		Date	