

Washington College
Office of Human Resources
300 Washington Avenue
Chestertown MD 21620

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

REPORT OF INJURY OR ACCIDENT:

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 PLEASE PRINT

1. Employee Name: _____ SS#: _____
2. Street Address: _____ City _____ State _____ Zip _____
3. Home Phone # _____ Cell # _____ Date of Birth _____
4. Date of Injury or Accident _____ Time _____ a.m. / p.m. Check if Cannot Be Determined

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 _____

2. 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 accident: Date _____ Time _____ a.m. / p.m.

4. Who reported this injury or accident to you and how did they report it to you (verbal, telephone call, left message): _____

5. Describe in detail what the employee reported to you they were doing when injured: _____

6. Describe in detail what the employee reported to you type injury or accident. (cut, scrape, bruise, sprain, break) Be specific. _____

