



North Country Community College  
 The College of Essex and Franklin  
 A Unit of the State University of New York

**Accident/Personal Injury Report**

**Please Print:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ Date of Hire: \_\_\_\_\_  
 Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_  
 Gender: { } male { } female Normal Work Hours: \_\_\_\_\_ Pass Days: \_\_\_\_\_  
 Job Title: \_\_\_\_\_ Department: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Day Employee Began Work on Date of Injury: \_\_\_\_\_  
 Time of Injury: \_\_\_\_\_  
 Regular Campus Work Location: \_\_\_\_\_  
 Place of Injury/Illness (be specific): \_\_\_\_\_  
 Nature and Part(s) of Body Affected (be specific – include left or right side if appropriate): \_\_\_\_\_  
 \_\_\_\_\_

Employee Remained on Duty: { } yes { } no Date of Absence: \_\_\_\_\_ Date Returned to Work: \_\_\_\_\_  
 Employee Required Medical Attention: { } yes { } no If yes, when? \_\_\_\_\_  
 Type of Treatment: { } first aid only { } emergency room { } doctor visit  
 Name and Address of Doctor: \_\_\_\_\_  
 Name and Address of Hospital: \_\_\_\_\_  
 Was employee hospitalized overnight? { } yes { } no

What was employee doing when injured? (be specific, identify tools, equipment, or material the employee was using) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How did the accident or exposure occur? (fully describe the events that resulted in the injury or occupational disease. Tell what happened and how it happened.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Object or substance that directly injured employee (e.g. "concrete floor", "radial arm saw", "chlorine", in the case of strains – identify the object that caused the strain, lifting, pulling, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Were there any witnesses? { } yes { } no If yes, list names and contact information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**IF FURTHER EXPLANATION IS NECESSARY FOR ANY OF THE ABOVE QUESTIONS, FEEL FREE TO ATTACH ADDITIONAL SHEETS.**

\_\_\_\_\_  
 Employee Signature Date  
 \_\_\_\_\_  
 Supervisor Signature Date

RETURN COMPLETED FORM TO THE DIRECTOR OF HUMAN RESOURCES