



# CONNORS STATE COLLEGE

## EMPLOYEE PERSONAL INJURY REPORT FORM

Employee's Full Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Last First Middle Initial

Home Address: \_\_\_\_\_  
Street Address City State Zip

Home Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Position: \_\_\_\_\_ Dept.: \_\_\_\_\_ Avg. Weekly Wage: \_\_\_\_\_

Length of Employment: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

Work Hours \_\_\_\_\_ o'clock  a.m.  p.m. until \_\_\_\_\_ o'clock  a.m.  p.m.

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ Place of Accident: \_\_\_\_\_

Identify part(s) of body involved in injury or illness \_\_\_\_\_

Explain how accident occurred: \_\_\_\_\_

Last date employee worked: \_\_\_\_\_ Has employee returned to work? \_\_\_\_\_

How much time was the employee off work? \_\_\_\_\_ Is validity in doubt? \_\_\_\_\_

List witnesses: \_\_\_\_\_

As supervisor of the above employee, I verify the above information pertaining to listed accident.

Date: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Date: \_\_\_\_\_ Employee: \_\_\_\_\_