

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Department: _____ Campus: _____ Date/Time of Injury: _____

Name of Employee: _____ SSN: _____

Accident Location: _____ Date/Time Started Work: _____

Job Title: _____ DOB: _____ Sex: M F Date Hired: _____

Employment Status: Full-Time Part-time Date/Time Supervisor Notified: _____

Job Classification: Administrator Faculty Classified Adjunct Faculty Temporary Hourly

Home Address: _____ Marital Status: M S
Street

City _____ State _____ Zip _____ Home Phone: _____

Accident Category: Check Type Motor Vehicle Equipment Employee Injury Property Damage

If Motor Vehicle Accident – Give Police Report No: _____

Vehicle Tag Number: _____ CCBC or Personal Vehicle

Type of Injury/Illness/Body Part: _____

Describe Accident: _____

List equipment, materials or chemicals employee used when accident/illness occurred: _____

Cause of accident: _____

Corrective action taken to prevent a recurrence: _____

Medical Treatment by (Name-Address-Date/Time): _____

Witnesses (Name & Phone): _____

Safety equipment used at time of accident? Yes No Was Accident Preventable? Yes No

Additional Comments (Use back if necessary):

Supervisor's Name (Print) Supervisor's Signature Date

Supervisor's Email Address Supervisor's Phone Number

Employee's Signature Date

Fax:
 CMU Copy – Fax #410-887-8426
 HR Copy – WC Fax #443-840-4841
(This Fax number is dedicated to
Worker's Compensation issues only)

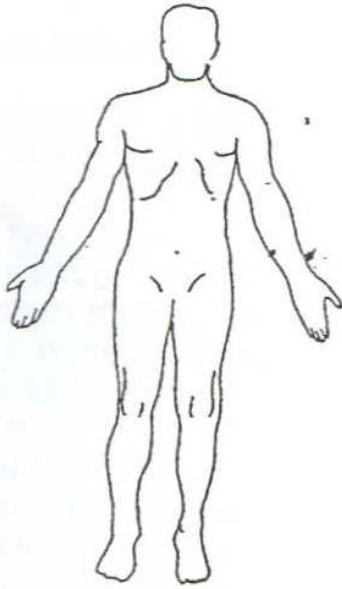
Send To:
 Original to HR
c/o Mary Livingston
(In envelope marked CONFIDENTIAL)

<p>HR Use Only: Rate of Pay: _____ Hrs. Worked Weekly: _____</p>
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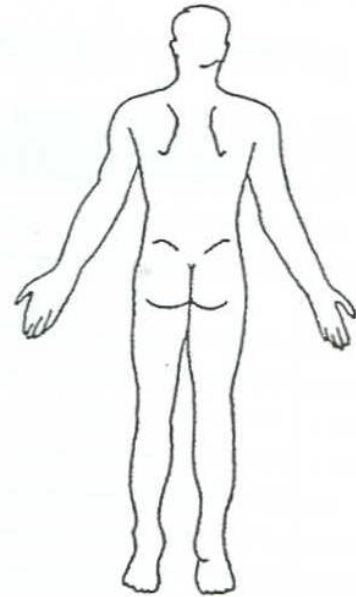


Name of Employee: _____

Circle injured body part, indicate left or right. Attach to Supervisor's Accident Report



Front



Back

Additional Comments Related to Injured Body Part (Please Print):

Witness Statement

Date/Time of Incident _____

Name of Injured Employee _____

Description of Incident (Witness Statement): Please Print

Witness Name/Title

E-mail Address/Telephone Number

Date