San José State
UNIVERSITY
FOUNDATION

SAN JOSE STATE UNIVERSITY FOUNDATION
EMPLOYEE ACCIDENT REPORT

NOTICE: This form is to be completed within 24 hours of the accident.

EMPLOYEE

1. NAME (Last, First, Middle Initial)

2. HOME ADDRESS(Please include City and Zip)

3. SOCIAL SECURITY NUMBER

4. HOME PHONE NUMBER

5. OCCUPATION (Job Title)

6. SEX ____ F ____ M

7. DATE OF BIRTH

8. DATE OF HIRE

9. EMPLOYEE'S DEPT. AND PHONE NUMBER

10. HOURS USUALLY WORKED: PER DAY? _____ DAYS PER WEEK? _____ TOTAL PER WEEK? _____

ACCIDENT

11. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, County)

12. DEPT. WHERE EVENT OR EXPOSURE OCCURRED, e.g. shipping, machine shop, etc.

13. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURED, e.g. acetylene, welding torch, scaffold, etc.

14. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g. welding seams of metal forms, loading boxes onto truck, etc.

15. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g. worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. Use separate sheet if necessary.

INJURY

16. NATURE OF INJURY (cut, strain, fracture, skin rash, etc.)

17. PART OF BODY INJURED (back, left wrist, right eye, etc.)

18. DATE, DAY AND HOUR OF ACCIDENT

DATE _____ DAY _____ HOUR OF DAY _____

19. WAS ANOTHER PERSON RESPONSIBLE FOR ACCIDENT? ____ YES ____ NO
IF YES, WHO?

20. WITNESSES AND THEIR ADDRESSES

21. ACTION TO PREVENT SIMILIAR ACCIDENTS (Indicate if taken or recommended)

22. ESTIMATE OF SEVERITY

____ Non-disabling (loss of less than a full day beyond the day of injury from normal activity

____ Disabling (loss of one or more full days of normal activity beyond the date of injury)

____ Fatal/Date of Death _____

____ Last day worked _____

23. EMERGENCY CARE & PATIENT STATUS

____ First Aid only, or treatment at Student Health

____ Treatment by medical personnel at office or Hospital (Include name and address of Physician)

____ Confinement at hospital, or in residence (Include name and address of Hospital)

____ Other, specify _____

SIGNATURE

It is the responsibility of the immediate supervisor of an employee who suffers a work-related injury or illness to:

A. See that the injured employee receives appropriate medical attention; and

B. See that the injured employee is transported to a doctor or hospital, if necessary, and returned to work or to the employee's place of residence; and

C. Investigate the accident and take immediate action to remedy unsafe conditions.

24. IMMEDIATE SUPERVISOR'S NAME (Print)

25. TITLE

26. SUPERVISOR'S CAMPUS ADDRESS

27. PHONE NUMBER

28. SUPERVISOR'S SIGNATURE

29. DATE