ITAWAMBA COMMUNITY COLLEGE

Employee Injury/Accident Report Form

Complete the entire form and return to the Human Resources office (fax: 662.862.8461 or email: humanresources@iccms.edu).

Employee Information

Employee Name: _____ Employee ID: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Email: _____

Date of Birth: _____ ☐ Male ☐ Female

Accident Information

Date of Injury/Incident: _____ Time of Injury/Incident: ____:____ a.m./p.m. Time Began Work: _____

Date Employer Notified _____ Exact Location of Injury/Incident:_____

Witness Name(s) and Contact Information: _____

Accident Description

What was the employee doing just before the accident occurred? Describe the activity, as well as the tools, equipment or materials the employee was using. Be specific:

Describe the events that caused the claimed injury/illness:

Describe claimed injury/illness (Be specific, i.e. sprain, strain, body part, left/right):

ITAWAMBA COMMUNITY COLLEGE

Treatment Information

First Aid Administered? Yes ☐ No ☐

Was there Medical Treatment? Yes ☐ No ☐ Hospitalized? Yes ☐ No ☐

First Medical Treatment Date: _____

Place of Treatment and Contact Information: _____

If yes to any treatment, explain:

Corrective Actions. Recommendations to Prevent Reoccurrence:

To the best of my knowledge these statements are correct, and I have received a copy of this report:

Employee Signature: _____ Date: _____

Review and submit as soon as possible to the Human Resources office.

Supervisor Signature: _____ Date: _____

For Office Use Only

Received By: _____

Employee Hire Date: _____

Employment Status: _____

Pay Rate: _____, per _____

Last Work Day: _____

Date Human Resources Was Notified: _____

Date Returned to Work: _____