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:____