Middlebury College Human Resources

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EMPLOYEE ACCIDENT/INCIDENT REPORTING FORM

REPORT ALL WORK ACCIDENTS OR INJURIES TO HUMAN RESOURCES WITHIN 24 HOURS

Name of employee:____

Date of Birth: __________________________ Social Security Number: __________________________________

Home Address: ____

City: __________________________ State: _______ Zip Code: _______ Telephone: ________________________

Employee ID#: ___________________ Date of injury: _________________ Time of injury: _________________

Time your work shift began: _________________ Supervisor: ____

Date notified: _______________________ Location of Accident: _______________________________________

Witness: _______________________________ Who did you notify? ____________________________________

Body part injured: __________________________________ Left or Right? _______________________________

Describe what happened & the injury:____

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Do you/did you need to seek medical treatment? (Circle one) Yes or No – not at this time

Please contact HR if your situation changes and you need medical care.

If you have a medical emergency, seek treatment immediately at the hospital ER

If your medical condition is not urgent, contact HR and you will be scheduled for an appointment with the College’s Occupational Health Specialist

EMPLOYEE SIGNATURE: ____ DATE:________________________

Once completed, please send this form to hr@middlebury.edu