Employee's Report of Injury (To Be Completed by the employee only.)

Employee's nar	ne: Last	First	Middle	Male Female
Date of birth:_				
Home address:				
City:			State:_	Zip Code:
Present classific	cation:			
How long emp	loyed by SSU :_		Social Security No.:	
Weekly salary:_				
Location of acc	eident: Addres	s Area	(loading dock, bathro	om, etc.)
Date of accider	nt:		Tim	ne of accident:
Describe bodily	injury sustaine	ed (be specific about	body part(s) affected):	
Kecommendati	on on how to p	prevent this accident	trom recurring:	

Name of supervisor	··	Phone #				
•	Last	First				
Name(s)witness(es):	·		Phone#			
	Attach witness(es) rep	port(s)				
When did you repor	rt the accident to your	supervisor?				
To whom did you r	eport the injury?					
Do you require med	lical attention? Yes:	No:	Maybe:			
Name of your treati	ng physician:		Pho	one#		
Signature of employ	/ee:			Date:		

Department of Administrative Services Risk Management Services

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