



**ACCIDENT REPORT**

Employee: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Location where accident occurred? \_\_\_\_\_

Did accident occur on college property? \_\_\_\_\_

Department where employed: \_\_\_\_\_ Date of injury: \_\_\_\_\_

Day of week: \_\_\_\_\_ Hour of day: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

First day unable to work: \_\_\_\_\_

Was injured paid in full for this day? \_\_\_\_\_

When was accident reported? \_\_\_\_\_

To whom was the report given? \_\_\_\_\_

Full name of injured: \_\_\_\_\_ Social Security: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Did injury occur during the performance of regular work assignment? \_\_\_\_\_

Injured party's job title: \_\_\_\_\_

How long have you been employed by Vernon College? \_\_\_\_\_

Name of friend/relative? \_\_\_\_\_ Phone number of friend/relative: \_\_\_\_\_

Cause of accident? \_\_\_\_\_

Kind of power (hand, electric, etc): \_\_\_\_\_

Safety regulation provided: \_\_\_\_\_

Was safety being observed at the time of accident: \_\_\_\_\_

Was accident caused by injured's failure to use or observe safety regulations? \_\_\_\_\_

Describe fully how the accident occurred and state what employee was doing when injured:

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Name and addresses of witnesses: \_\_\_\_\_

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Describe the injury in detail and indicate the part of the body affected: \_\_\_\_\_

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Probable length of disability, if applicable: \_\_\_\_\_

Name and address of Physician: \_\_\_\_\_

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Name and address of Hospital: \_\_\_\_\_

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Date of Report: \_\_\_\_\_ Employee's signature: \_\_\_\_\_

Submit report to: Human Resources Office  
Vernon College  
4400 College Drive  
Vernon, Texas 76384