ACCIDENT REPORT

IF YOU ***ARE NOT*** CURRENTLY ON BENEDICTINE'S PAYROLL, PLEASE CONTACT YOUR EMPLOYER TO FILE A CLAIM.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME:	**SUPERVISOR NAME:**
DEPARTMENT:	**JOB TITLE:**
DATE OF ACCIDENT:	**TIME OF ACCIDENT:**
EMPLOYEE'S DATE OF BIRTH: **EMPLOYEE'S DATE OF HIRE:**	**EMPLOYEE HOME ADDRESS:**
EMPLOYEE HOME NUMBER:	**EMPLOYEE SS#:**

What were you doing just before the incident occurred? Describe the activity, as well as tools, equipment, or material the employee was using.

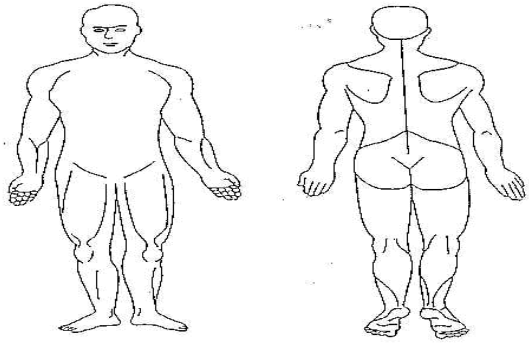
What happened? Tell us how the injury occurred.

Where did the accident happen? Name specific building and location.

What object or substance directly harmed you? Ex. Concrete floor; chlorine. If this question does not apply, leave it blank.

PART OF BODY AFFECTED (Please circle Left or Right where applicable) (Please circle affected body part on chart below)

- ☐ ARM/ELBOW L / R
- ☐ FOOT/ANKLE L / R
- ☐ NECK
- ☐ BACK
- ☐ HAND/WRIST L / R
- ☐ RESPIRATORY
- ☐ CHEST/ABDOMEN L / R
- ☐ HEAD/FACE
- ☐ SHOULDER L / R
- ☐ EYE L / R
- ☐ HIP/BUTTOCKS/GROIN L / R
- ☐ TOE L / R
- ☐ FINGER/THUMB L / R
- ☐ LEG/KNEE L / R
- ☐ OTHER _____



DID ANYONE WITNESS THIS ACCIDENT? _____ (initial) YES _____ (initial) NO
IF YES, LIST NAMES, ADDRESS & PHONE NUMBER OF WITNESS. Attach additional info. if needed.
Witness #1:
Witness #2:

ARE YOU SEEKING OR REFUSING MEDICAL TREATMENT AT THIS TIME?
_____ (initial) SEEKING MEDICAL _____ (initial) REFUSING MEDICAL
I acknowledge that by declining medical treatment I may jeopardize my work. comp. claim status. _____ (initial)
The state of KS allows denial of all claims not filed within 20 days of accident. _____ (initial)

THE ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE SIGNATURE: **DATE:**

BENEDICTINE COLLEGE

THIS SECTION TO BE COMPLETED BY SUPERVISOR

DATE NOTIFIED:	INCIDENT HAPPENED ON BENEDICTINE PREMISES: ☐ YES ☐ NO
EMPLOYEE'S JOB TITLE:	WAS THE EMPLOYEE PERFORMING HIS/HER NORMAL DUTIES? ☐ YES ☐ NO
HOW LONG HAS EMPLOYEE BEEN DOING THIS PARTICULAR JOB?	
WHAT WAS THE EMPLOYEE DOING WHEN THE ACCIDENT OCCURRED? *(Be brief and specific)*	LOCATION OR AREA WHERE ACCIDENT OCCURRED:

TYPE OF INJURY

- ☐ SLIP/FALL
- ☐ CAUGHT IN/BETWEEN/ON
- ☐ STRUCK BY (Hit or moving object)
- ☐ STRUCK AGAINST (bumping into)
- ☐ CONTACT WITH (electricity, heat, cold, noise, toxics)
- ☐ OVERSTRESS/OVER EXERTION/REPETITIVE MOTION
- ☐ INJURY FREE OR UNKNOWN

NATURE OF INJURY

- ☐ AMPUTATION
- ☐ BLISTER/BUMP
- ☐ BURN
- ☐ BRUISE/CONTUSION
- ☐ CUT/LACERATION
- ☐ FOREIGN OBJECT IN EYE
- ☐ FRACTURE
- ☐ INSECT BITE
- ☐ IRRITATION/REDNESS
- ☐ PUNCTURE WOUND
- ☐ RESPIRATORY
- ☐ SCRATCH/ABRASION
- ☐ SPLINTER/SLIVER
- ☐ SPRAIN/STRAIN
- ☐ SWELLING

Describe clearly what happened. Explain what the Employee was doing before and when the accident happened.
List any conditions or actions that may have contributed to the incident.

_____

_____

_____

_____

_____

_____

Did the Employee have lost time beyond his / her regular shift? ☐ YES ☐ NO, If yes, how much time?

Was the Employee compensated for the full day? ☐ YES ☐ NO, If not, how many hours were not paid?

PLEASE IDENTIFY ANY CORRECTIVE ACTION NECESSARY TO ASSURE THIS ACCIDENT DOES NOT OCCUR AGAIN.

SUPERVISOR: DATE:

After complete, turn in to Human Resources Department within 24 hours of accident.

THIS SECTION TO BE COMPLETED BY HUMAN RESOURCES

DATE RECEIVED: REVIEWED BY:

WAS EMPLOYEE SENT FOR MEDICAL ATTENTION? ☐ YES ☐ NO

ADDITIONAL INFORMATION:

TYPE OF ACCIDENT:

☐ INJURY FREE ☐ FIRST AID ☐ OSHA REPORTABLE

☐ INJURY ☐ ILLNESS ☐ RESTRICTED DUTY LOST TIME: _____