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| --- | --- | --- | --- | --- |
| **WORKER'S COMPENSTION ACCIDENT INVESTIGATION** | | | | |
| **Elon University Office of Human Resources** | | | | |
| Complete and SCAN to Amanda Jo Johnson RN, CCM jjohnson102@elon.edu | | |  |  |
|  |  |  |  |  |
| **Injured Information** | | | | |
| **Name** | **Date of Birth** | **Hire Date** | **Date of Injury** | **Time of Injury** |
| **Home Address** | **Phone Number** | **Gender** | **Email** |  |
| **Department** | **Job Title** |  | **Supervisor** | **Dept Extension** |
| **Location of Accident** | **Employment Status** | **Work Hours** |  |  |
|  | **\_\_\_\_ Full Time** | **\_\_\_\_ 8 to 5** | **\_\_\_\_ # Hours per day** | |
|  | **\_\_\_\_ Part Time** | **\_\_\_\_ 7 to 4** | **\_\_\_\_ # Hours per week** | |
|  | **\_\_\_\_ Other** | **\_\_\_\_ Other** |  |  |
| **Description of Accident** |  |  |  |  |
| **Body Part Injured Specify Left or Right** | **Was Safety Equipment Used If not Explain** | | |  |
| **Did Injured Seek Medical Treatment** | **Where was Treatment Provided** | | **\*\*\*\*\*USE WELLNESS IF OPEN** | |
| \_\_\_\_\_ Yes |  |  |  |  |
| \_\_\_\_\_ No |  |  |  |  |
| **Was EMS Used** | **Disposition** |  |  |  |
|  | **\_\_\_\_\_ Returned to Work Without Restrictions** | | |  |
|  | **\_\_\_\_\_ Returned to Work Light Duty Until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
|  | **\_\_\_\_\_ Out Of Work Until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |  |
|  |  |  |  |  |
| **Supervisor Completing Form** | **Supervisor Extension and Email** | |  | **Date** |
| university AccidentInvestigationFormWorkersComp.pdf -revised 12/20/18 | |  |  |  |