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** **____ Full Time** **____ Part Time** **____ Other**	**Work Hours** **____ 8 to 5** **____ 7 to 4** **____ Other**	**____ # Hours per day** **____ # Hours per week**	
Description of Accident				
Body Part Injured Specify Left or Right	**Was Safety Equipment Used If not Explain**			
Did Injured Seek Medical Treatment _____ Yes _____ No	**Where was Treatment Provided** *******USE WELLNESS IF OPEN**			
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**	