Assigned Campus/Site: Department and Supervisor name:		RT	ENT REPOR	ACCII	IPLOYE	EN					SOUTHSIDE V COMMUNITY	
Assigned Campus/Site: Department and Supervisor name:												
Name of employee	s Date.	Today s Da		ted								
Phone Home: Work: Cell: State: Sex: Maile Female Number of dependents: COVID: Address: City: State: State: Covid: State: S	727	48.00		S CAMP S N	Carlo Victory	Maria I	32.75			Fight St	ployee	
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Marital Status: Employment Status: ex. wage, full-time, adjunct			COVID:									
ex. wage, full-time, adjunct	Zip:	State:				City:					dress:	
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Was employee paid on day of injury? Date injury or illness reported: Person to whom reported: Name of or yes No Nature of injury: Probable length of disability (if known): Nature and Cause of Accident rescribe fully how injury or illness occurred: Address: Overnight inpatient hospitalization? Treated in each injury: Parts of body affected: Yes No Yes	remises:			e	-		-		Etc.):	Bldg., Rm.	cific Location of Accident (
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Has employee lost time from work: Yes No Nature and Cause of Accident Describe fully how injury or illness occurred: Cause of injury: Nature of injury: Parts of body affected: Machine, tool, or object causing injury or illness: Overnight inpatient hospitalization? Treated in each or injury: Treating Physician (name): Address: City: State of injury: Overnight inpatient hospitalization? Treated in each or injury: State of injury: Nature of injury: Parts of body affected: Overnight inpatient hospitalization? Treated in each or injury: State of injury: Nature o	her witness:	Name of other w		om reporte	Person to		orted:	or illness rep	Date injury	injury?	s employee paid on day of i	
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Does employee have VSDP coverage? Does employee have Ctate Health Inc ? If the Provide warms.	one:	3	The state of the s									
	ite:	s, Provider name: Effective Date:			If yes, Prov							
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