SOUTHSIDE VIRGINIA COMMUNITY COLLEGE

EMPLOYEE ACCIDENT REPORT

Your reason for completing this report:
☐ Injured Employee ☐ Accident reported to you as Supervisor; Date Reported_____ Today's Date:_____

Assigned Campus/Site:	Department and Supervisor name:

Employee

Name of employee

Last:	First:	Middle:

Phone

Home:	Work:	Cell:
Sex: ☐ Male ☐ Female	Number of dependents:	COVID:

Address:	City:	State:	Zip:
Marital Status:	Employment Status: ex. wage,full-time, adjunct		
Occupation at time of injury/illness:	Date of Hire:		

Time and Place of Accident:

Specific Location of Accident (Bldg., Rm., Etc.):	☐ Outside ☐ Inside ☐ Wet ☐ Dry	On Employer's Premises: ☐ Yes ☐ No

Date of injury:	Hour of injury: ___:___**am**☐ **pm**☐	Time began work: ___:___**am**☐ **pm**☐	Date of Incapacity:	Hour of Incapacity: ___:___**am**☐ **pm**☐

Was employee paid on day of injury? ☐ Yes ☐ No	Date injury or illness reported:	Person to whom reported:	Name of other witness:

Has employee lost time from work: ☐ Yes ☐ No	Probable length of disability (if known):

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? ☐ Yes ☐ No	Treated in emergency room? ☐ Yes ☐ No

Treating Physician (name): Only complete if medical attention already received.	Address:	City:	State:	Zip:
Hospital/Clinic (name): Only complete if medical attention already received.	Address:	City:	State:	Zip:

Were safety regulations violated? ☐ Yes ☐ No	Was a third party responsible for injury? ☐ Yes ☐ No	If yes, 3rd party name:

3rd party address:	3rd party phone:

Does employee have VSDP coverage? ☐ Yes ☐ No	Does employee have State Health Ins.? ☐ Yes ☐ No	If yes, Provider name:	Effective Date:

This information is required by the Virginia Worker's Compensation Act **Employee Accident Report**

PREPARED BY (signature):_____ (name printed):_____ TITLE_____