Worker's Compensation Accident Report Form

Completed form should be emailed to mfisher9@elon.edu or mailed to Campus Box 2110.

Employee Information

Legal Name: ____

Date of birth: ______________________ Phone number: _________________________________

Supervisor's name: ____

Primary Language English Spanish

Shift worked: 1st 2nd 3rd

Accident Information

Date of Injury: __________________________ Time of Injury: ______________ AM/PM

Location of Accident: ____

Witness Contact Information (if applicable):

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Description of Accident (be as specific as possible):

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Was a university vehicle involved? Yes No

Did you seek treatment at the Faculty/Staff Health & Wellness Clinic? Yes No

Did you seek treatment at another medical facility? Yes No

If so, where? ____

Did you return to work after medical treatment? Yes No

Employee Signature and Date: ____