ELON UNIVERSITY

Submit by Email
Print Form

Office of Human Resources

Elon University Accident Investigation Form for Worker's Compensation

Please PRINT or TYPE the following information and email this completed form to Jo Boone at boonejo@elon.edu. Please note: If employee does not have access to a computer, please print all pages and mail to Jo Boone at CB 2070.

Supervisor to Complete

Legal name of injured _____ SSN ☐☐☐☐☐☐☐☐☐☐☐
(enter without dashes)

Date of birth _____ Age ____ Phone # ☐☐☐☐☐☐☐☐☐☐
(mm/dd/yyyy) (enter without dashes)

Home address _____

City _____ State _____ Zip _____

Gender ◯ M ◯ F Marital Status ◯ Married ◯ Single ◯ Widow ◯ Divorced # of dependents _____

Employee primary language ◯ English ◯ Spanish ◯ Other

Accident reported to supervisor ◯ Yes ◯ No

Employment status
- ◯ Temporary
- ◯ Part-time
- ◯ Full-time
- ◯ Adjunct
- ◯ Faculty

hours worked/shift
- ◯ 8 to 5
- ◯ 7 to 4
- ◯ Other _____

hrs/day _____
hrs/week _____
months worked/year ____
over-time hrs worked/week _____

Accident Information

Date of injury _____ Time of injury _____

Job title _____ Department _____

Location of accident _____ Normal Work Area ◯ Yes ◯ No

Witness to Accident _____

Description of Accident

Body Parts Injured ◯ Left ◯ Right

Did employee get injured on the job? ◯ Yes ◯ No Explain: _____

Was employee doing their regular job? ◯ Yes ◯ No Explain: _____

Was employee paid in full for the day of the injury? ◯ Yes ◯ No Explain: _____

Was any safety equipment provided and used? ◯ Yes ◯ No Explain: _____

Was any unsafe act being performed? ◯ Yes ◯ No

Describe:

Was a machine part involved? ◯ Yes ◯ No Explain: _____

Was the machine part defective? ◯ Yes ◯ No If yes, in what way? _____

Did the employee seek medical treatment for their accident? ◯ Yes ◯ No

Did the employee receive treatment at RN Ellington Health Center? ◯ Yes ◯ No

If no, explain why not:

Facility employee sought medical treatment from if other than RN Ellington Health Center _____

Did supervisor give permission to employee to visit this facility? ◯ Yes ◯ No

Did supervisor explain to employee our procedures about seeking medical treatment? ◯ Yes ◯ No

Did employee return to work without restrictions after treatment? ◯ Yes ◯ No

Did employee return to work on light duty? ◯ Yes ◯ No

What restrictions?

Was employee hospitalized? ◯ Yes ◯ No If yes, what facility _____

Number of days employee is expected to miss from work _____

Supervisor completing this form _____ Date: _____

Person injured to complete

Employee must write in their own words a statement about the accident. This must be attached to the Accident Investigation Form.

Name _____ SSN | | | | | | | | | | | |
(enter without dashes)

Date of birth _____ Gender ◯ M ◯ F
(mm/dd/yyyy)

Job title _____ CB: _____

Home address _____

City _____ State _____ Zip _____

Supervisor's name _____

Date of injury _____ Time of injury _____

Location of injury _____

In your own words describe what happened and whether or not you sought medical treatment:

Did you seek medical treatment at this time? ◯ Yes ◯ No

If yes, where did you seek treatment? _____

Witness(es) to the injury:

Name _____ Phone extension _____

Signature _____ Date _____

Name _____ Phone extension _____

Signature _____ Date _____