WILLIAM & MARY | UNIVERSITY HUMAN RESOURCES
CHARTERED 1693

First Report of Accident, Injury, or Illness Form

Please notify University Human Resources the following information regarding the employee's work-related accident, injury, or illness **within 24 hours**. Send all completed forms, photos, and physician notes to UHR via AskHR@wm.edu, fax at 757-221-7724, or uploaded to our secure Box folder. The employee is required to select from a panel of medical specialists for medical treatment as mandated by the Virginia's Workers' Compensation Act. For questions, contact UHR at 757-221-3169.

Employee Information

Name (last, first middle initial)	
Banner ID	
Mailing Address	
Phone	
Date of Birth	
Sex	◯ Male ◯ Female
Position / Department	
Employee Classification	☐ Hourly ☐ Classified ☐ Faculty ☐ Other (explain): ☐ Operational or Professional

Information about Time/Place of Accident, Injury, or Illness

City or County where this accident, injury, or illness occurred			
Exact Location			
Date of accident, injury, or illness		Time of Accident, Injury, or Illness	◯ am ◯ pm
Date accident, injury, or illness reported			
Were you paid in full for the day of the accident?	◯ Yes ◯ No Explanation:		
Supervisor's Name			
Was supervisor notified?	◯ Yes ◯ No		
Name of Witness(es)			

Information about the Nature and Cause of Accident, Injury, or Illness

Describe fully how accident, injury, or illness occurred.	
Describe nature of accident, injury, or illness, and describe body part(s) affected. Include right or left side(s).	
Machine, tool, or object causing accident, injury, or illness	
Was safety equipment used?	◯ Yes ◯ No ◯ N/A
	If so, what kind?
Was medical treatment provided by a medical professional?	◯ Yes ◯ No
	Where?
Was time lost from work?	◯ Yes ◯ No
	If yes, how long?
Date returned to work	
Could this accident, injury, or illness have been avoided?	◯ Yes ◯ No
	If yes, how?

Employee Signature: Date:

Supervisor Signature: Date: