

The College of William and Mary/Vims **Employee's First Report of Accident/Injury Form**

Please provide the Office of Human Resources the following information as soon as it relates to your work related accident/injury/illness within **72 hours**. Send this completed form to Carole Shaver, Human Resources Phone : 757-221-3160 or fax: 757-221-3156. You are required to select from a panel of medical specialists for medical treatment as mandated by the Virginia's Workers' Compensation Act.

Employee Information

Name		SSN	
Address		Cell Phone	
City		Home Phone	
State		Work Phone	
Zip Code	Marital Status:	Single	Married Divorced Widowed
Date of Birth	Sex:	Male	Female
Occupation		Department	
Work Hours Per day	Days per week	Time work begins	
Emp Type:	Hourly	Classified	University Faculty Other

Information About Time/Place of Accident

City or County where this accident occurred :			
Exact Location :			
Date of Accident :	Time of Accident	AM	PM
Date accident reported :			
Were you paid in full for the day of the accident?			Yes No
Supervisor's Name		Was supervisor notified?	Yes No
Name of Witness(es):			

Information About the Nature and Cause of Accident

Machine, tool or object causing injury			
Was safety equipment used?	Yes No	If so, what kind?	
Describe fully how injury occurred :			
Describe nature of Injury and describe body part affected (to include right or left side) :			
Was medical treatment provided?	Yes No	Where	
Was time lost from work?	Yes No	If yes, how long?	
Date returned to work			
Could this accident have been avoided?	Yes No	If yes, how?	

Employee Signature	Date
Supervisor Signature	Date