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 **24 hours**. Send this completed form to Human Resources.
Phone : **757-221-3769** or fax: **757-221-7724**. Your 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

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