



REPORT OF ACCIDENT/INJURY
Butte-Glenn Community College District

Personal/Position Information

Name of Injured Employee _____

Date of Birth: ____/____/____ Social Security No.: ____-____-____ Phone: (____) ____-____

Address: _____ City: _____ State: _____ Zip: _____

Department: _____ Job Title: _____ Sex: M F

Normal Work Schedule: Hours per day: _____ Days Per Week: _____

Injury Information

Date of Accident: ____/____/____ Hour: ____ Date Reported: ____/____/____ Hour: ____

Accident Location: _____ Time Employee Started Work: _____

What was employee doing when injured? _____

How did the accident occur? _____

Describe the injury or illness and part of body affected. _____

Did employee seek medical care? Yes No
If Yes, name of medical facility. _____

Did employee leave work? Yes No
If yes, Date: ____/____/____ Time: _____

Did employee return to work? Yes No
If yes, Date: ____/____/____ Time: _____

Witnesses (If more space needed, use back of sheet.)

Name	Phone
_____	(____) ____-____
_____	(____) ____-____
_____	(____) ____-____

What steps have been taken to prevent a similar accident? _____

Completed By: _____ Date: ____/____/____ Time: _____

Please Note: This form must be completed and submitted to the HR Benefits Analyst (879-4049) immediately upon your knowledge of a work-related accident. Report all possible unsafe conditions to Facilities Planning and Management (895-2381).