Accident investigation forms/statements should be completed by the injured employee, supervisor and any witness within 72 hours of the accident. Follow the instructions below for appropriate reporting and workflow directives.

1. Injured employee to complete **Employee Report of Injury** form
2. Witness to complete the **Accident Witness Statement** form.
3. Supervisor to complete **Supervisor Incident Report** form.
4. Submit all completed forms to The Office of Human Resources.
5. HR will process the claim (processing does not automatically approve the claim) and provide claim # and Concentra instructions to employee.
6. Regular state employees code their timesheet with "ACT" for any absences related to the submitted claim.

Office of Human Resources

HR--0001

ACCIDENT INVESTIGATION REPORT

EMPLOYEE REPORT OF INJURY

Employee Full Name:

Date of Birth: ☐ Male ☐ Female

Home Telephone:

Home Address:

City/State/Zip:

Marital Status: Select One: Classification: Select One:

Current Job Position: Date of Hire:

Employee ID:

Supervisor Name:

Name of Witness(es): PHONE #:

Date of Accident: Time of Accident:

Location of Accident: (i.e. campus location, bldg, etc.)

Describe how the accident occurred:

Describe bodily injury sustained (be specific about body part(s) affected:

Do you require medical treatment: ☐ YES ☐ NO

If yes, please contact the OHR at 443-885-4477 or via workerscompensation@morgan.edu

Employee Signature: Date:

Accident investigation forms/statements should be completed by the injured employee, supervisor and any witness within 72 hours of the accident. Follow the instructions below for appropriate reporting and workflow directives.

1. Injured employee to complete **Employee Report of Injury** form
2. Witness to complete the **Accident Witness Statement** form.
3. Supervisor to complete **Supervisor Incident Report** form.
4. Submit all completed forms to The Office of Human Resources.
5. HR will process the claim (processing does not automatically approves the claim) and provide claim # and Concentra instructions to employee.
6. Regular state employees code their timesheet with "ACT" for any absences related to the submitted claim.

Office of Human Resources

HR001-B

ACCIDENT INVESTIGATION REPORT

ACCIDENT WITNESS STATEMENT

Injured Employee's Name:

Name of Witness: Phone:

Job Title of Witness:

Is witness related to injured employee? Select: if "yes" how?

Date of Accident: Time of Accident:

Location of Accident: (i.e. campus location, bldg, etc.)

Describe witness of accident:

Witness Signature: Date:

Name of Additional Witness: Phone:

Job Title of Witness:

Is witness related to injured employee? if "yes", how?

Date of Accident: Time of Accident:

Location of Accident: (i.e. campus location, bldg, etc.)

Describe witness of accident:

Witness Signature: Date:

Send completed form to workerscompensation@morgan.edu.

Accident investigation forms/statements should be completed by the injured employee, supervisor and any witness within 72 hours of the accident. Follow the instructions below for appropriate reporting and workflow directives.

1. Injured employee to complete **Employee Report of Injury** form
2. Witness to complete the **Accident Witness Statement** form.
3. Supervisor to complete **Supervisor Accident Report** form.
4. Submit the completed packet of forms to The Office of Human Resources.
5. HR will process the claim (processing does not automatically approves the claim) and provide claim # and Concentra instructions to employee.
6. Regular state employees code their timesheet with "ACT" for any absences related to the submitted claim.

Office of Human Resources

HR001-B

ACCIDENT INVESTIGATION REPORT

SUPERVISOR ACCIDENT REPORT

Supervisor's Name: Phone Number:

Injured Employee's Name:

Date of Accident: Time of Accident:

Did the accident occur on employer's premises?: ☐ Yes ☐ No
If no, please specify accident location:

Were you immediately notified of the accident?: ☐ Yes ☐ No

What was the employee doing when injury/illness occurred?:

What machine or tool was being used?

How did injury/illness occur?

Was this accident the result of another party's negligence? Select One:

Part of body affected/injured?

Was there any property/material damage? Please specify.

Do you have any concerns about this alleged accident or injury? If so, please specify?

- Was employee trained in the appropriate Personal Protective Equipment/proper safety procedures? ☐ Yes ☐ No
- Was employee using safety procedures at the time of accident? ☐ Yes ☐ No
- Is there modified duty available? ☐ Yes ☐ No

Supervisor Signature: Date:

Send completed form to workerscompensation@morgan.edu.