Champlain College Injury Report

(rev. 2-5-2015)

EMPLOYEE'S NAME:

DATE OF INCIDENT: Time of incident:

DATE REPORTED TO SUPERVISOR/HUMAN RESOURCES:

Employee information

Home mailing address:

Home/cell phone: Work phone:

Email:

Title: Department:

Supervisor's name/phone/email:

Incident information

Description of incident:

Location of incident:

Description of injury:

Did you have a prior injury or pre-existing condition?:

Names of Witnesses:

Medical information

Did you receive first aid? If so, describe:

Did you go to a hospital? If so, name of hospital:

Describe medical treatment received:

Name of medical provider:

Medical provider's address/phone:

Lost time due to incident:

Are you back at work at this time?:

Do you have light/modified duty?:

Signature of employee:

By:____________________________________ Date:_______________

For Human Resources:

Social Security:

Full time/Part time:

Date of Birth:

Date of Hire:

Date claim reported to Travelers:

CLAIM NUMBER:

Claim representative: