College of the Holy Cross/Hu

Employee name: _____

Address: _____

City: _____

Phone: _____

Sex: (circle one) Male Female

Department: _____

Supervisor's name: _____

Normal shift hours from _____

Normal work days: (please circle) _____

Date of accident: _____

Estimated time of accident: _____

Date supervised notified: _____

Nature and location of injury:

Full description of the cause of inj

If treated elsewhere, name and address of physician and/or hos

First lost day of work: _____ Restricted duty from

Employee returned to work? Yes No If yes, date & hour: _____

_____ date of this report

_____ employee signature

Revised 12/5/2013