

General Accident Report Form

COMPLETE REPORT WITHIN 24 HOURS OF ACCIDENT AND ROUTE REPORT TO SECURITY, HO-119

If filing a Workers' Comp claim, this form must accompany claim.

Personal Information:

Name of Person (print) _____ Male Female
 Student Employee Visitor Co-op child Work study CWE
Home address _____ Home phone _____
Date of birth _____ Personal health/accident insurance _____
ID Number _____ LBCC Department _____ Ext. # _____
Supervisor or instructor's name (print) _____ Notified? Yes No

Injury/Illness Information:

Date of accident/illness _____ Time _____
Location (building & room) _____ Address (if off campus) _____
Person was in: class work situation ** Other _____

***Employee and workstudy on-the-job injuries/illnesses that require medical attention or involve time loss are to be recorded on a Workers Compensation, OR State 801 form, available in the Human Resources Office, CC-113.*

Describe injury (part of body affected) _____

Describe how accident occurred _____

Describe why injury/illness occurred and basic cause (wrong equipment, lack of training, unsafe condition, etc.)

Name, address and phone number of all witnesses:

Person filing report (print) _____ Phone # _____

Signature _____ Date _____

TO BE COMPLETED BY SUPERVISOR or INSTRUCTOR

Recommendation to prevent reoccurrence including resolutions/actions taken:

Name of instructor or supervisor: _____ Signature: _____

First aid administered by _____

Describe first aid administered, transport to medical facility by whom _____

Original to Security _____ Copy to: Human Resources _____ Risk Management _____ Student Services _____