St. Bonaventure University
Employee Accident Report Form

Employee name: _____ Department:_____

Date of this report: _____ Date and time of accident: _____

Location of accident: _____

Description of accident: (include narrative of what you were doing at the time of injury, what safety equipment you were using, what machinery you were operating, etc.)

_____
_____
_____
_____
_____

Object or substance that directly caused injury/ illness:

_____
_____

Nature of injury:

_____
_____

Name (s) of witness (es):

_____
_____

Date incident reported to supervisor: _____

Did you seek medical attention: Yes _____ No _____ What date: _____
Where: _____

Did this incident cause you to lose time from work: Yes _____ No _____
First lost date: _____

Employee signature: _____

February 2009