**St. Bonaventure University**
**Supervisor's Report of Accident/Injury/Illness/Incident**

Injured Employee Name _____ Date of Accident _____

Time of Accident _____ Dept _____ Position _____

Accident Site _____ Date Reported to Supervisor _____

Nature of injury/body part affected _____
_____

Description/cause of accident/what employee was doing when injury occurred
_____
_____
_____
_____
_____

Did employee receive medical attention?_____ Where? _____
_____

Will employee lose time from work? _____ Expected return date _____

Name(s) of Witness: _____

Action taken to prevent similar occurrences: _____
_____

Supervisor's signature _____ Date _____

(Do not write below this line)

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Human Resources Reporter _____ Date of Report _____

EE SSN _____ EE Date of Birth _____ EE Date of Hire _____

Employee Address _____ Phone _____

_____ Record Only _____ First Aid Only _____Report to Wrks Comp