Accident Report Form
For Workers’ Compensation Benefits
(To be completed immediately after a workplace accident)

Employee Information
To be completed by the employee

Last Name: ___________________________ First Name: ___________________________ UNI: ____________
Cell Phone: ___________________________ Employee Affiliation/Type: Please Select
HR Departmental Contact (if known): ___________________________ HR Departmental Contact Email (if known):

Accident Information
To be completed by the employee—all questions required

Date of injury /illness (mm/dd/yyyy): ____________ Time of injury/illness: ______ AM □ PM □ Time you started work: ______ AM □ PM □
Location (building, room) where injury/illness occurred: __________________________________________________________
What were you doing when injury/illness occurred? : __________________________________________________________

Type of Injury
Please Select
• Bite/ Scratch☐ □ Bodily reaction☐ □ Caught in/ Under/ BTN☐ □ Contact w/ Chemical☐ □ Contact w/ electrical☐ □ Extreme temperature☐ □ Exposure☐ □ Fall from elevation☐ □ Fall on the same level☐ □ Motor Vehicle☐ □ Needle Stick☐ □ Overexertion☐ □ Puncture☐ □ Rubbed/ Abraded☐ □ Slip/ trip☐ □ Struck Against☐ □ Struck By☐ □ Other (describe below)
If Exposure, Select Type
• Dermal☐ □ Injection☐ □ Inhalation☐ □ Ingestion☐ □ Description (if not above)

Nature of Injury
Please Select
• Abrasion☐ □ Animal bite or scratch☐ □ Burn☐ □ Chemical spill☐ □ Chemical exposure☐ □ Contusion☐ □ Crushed☐ □ Foreign Body☐ □ Fracture☐ □ Illness/ infection☐ □ Laceration☐ □ Needle Stick☐ □ Puncture☐ □ Rash☐ □ Repetitive motion☐ □ Sprain/ Strain☐ □ Struck By/ Against☐ □ Other (specify below)
Lab Accident? Yes☐ □ No☐ □ Description (if not above)

Body Part
Please Select
• Abdomen☐ □ Ankle☐ □ Elbow☐ □ Disc (Back)☐ □ Fingers☐ □ Foot☐ □ Groin☐ □ Head☐ □ Knee☐ □ Lower Back☐ □ Multiple Body Parts☐ □ Multiple Neck Injury☐ □ No Physical Injury☐ □ Pelvis☐ □
Right Side☐ □ Left Side☐ □
Description (if not above)
__________________________

Were you seen in an emergency room? Yes☐ □ No☐ □ Were you hospitalized overnight as an inpatient? Yes☐ □ No☐ □
Was there contact with any blood or bodily fluids? Yes☐ □ No☐ □ What object directly harmed you? ___________________________
Were you harmed by a sharp object? Yes☐ □ No☐ □ To whom did you report the accident (name): ___________________________
Date Reported: (mm/dd/yy)_________ Time reported: ____________ Witness Name (if known):
Witness's Email ___________________________ Witness’s Cell Number ___________________________
Signature

I CERTIFY THAT THE ACCIDENT INFORMATION PROVIDED ABOVE IS TRUE.

Completed By Employer ☐ Completed By Supervisor ☐ EMPLOYEE Signature: ____________________________ Date (mm/dd/yyyy)

Submitting Your Accident Report

This form is only complete after it has been submitted to Leave Management, Environmental Health and Safety, and either your HR Departmental contact or your Supervisor.

Please submit this form by scanning and sending it to Leavemanagment@columbia.edu and occusafety@columbia.edu.