WTC INJURY REPORT FORM

Today's Date:				
Employee Name:			SSN:	
Nature of Incident:				
Department/Program:			Schedule:	
Date and time of Injury/ Accident:				
Date, time and name of the person the accident was reported to:				
Type of Injury:				
How did the injury occur?:				
Location of incident:				
Was 911 Called?		Was 911 refused? If yes, by whom?		
Were routine duties being performed at the time of the injury?				
If duties were not routine, were they in the scope of the job?				
Was aid administered? If so, by whom?				
Was the injured employee transported somewhere else?				
Were there any unusual circumstances?				
How could this injury have been prevented?				
Action taken:				
Witness(es):	Name:	Address:	Phone:	
Signatures:	Employee	Supervisor/ Director	Campus Director	
	Date:	Date:	Date:	

FOR ADDITIONAL COMMENTS, USE REVERSE SIDE

Additional Comments: