

**BARNARD COLLEGE  
ACCIDENT REPORT**

Name of Injured \_\_\_\_\_

Home Address \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Department where

Regularly employed \_\_\_\_\_ Occupation \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

Location of Accident \_\_\_\_\_

Description of

Accident \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Part of body injured \_\_\_\_\_

Did employee lose any time from work Yes \_\_\_\_\_ No \_\_\_\_\_

Was medical care provided? Yes \_\_\_\_\_ No \_\_\_\_\_

Lost days if known \_\_\_\_\_

Returned to work date \_\_\_\_\_

Name of Hospital \_\_\_\_\_

Accident Witness \_\_\_\_\_

Date of Report \_\_\_\_\_

Signature \_\_\_\_\_

Employee

Supervisor

Please maintain copy for your records

Send original to: Personnel Benefits Department, Milbank Hall, Room 6

Accrpt/6/97