

OKLAHOMA BAPTIST UNIVERSITY

Office of Human Resources

Accident or Injury Report

Employee's Report of Accident or Injury						
Employee Name:						
Location:			Attending physician:			
Occupation:				Age:		
Date of injury:			Time:	<input type="checkbox"/> A.M.	<input type="checkbox"/> P.M.	
Nature of injury (such as strain, cut, or bruise):						
Part of body that was injured (such as left hand or right ankle):						
Did you return to work?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Time:	<input type="checkbox"/> A.M.	<input type="checkbox"/> P.M.
Where and how did the accident happen?						
Specify any equipment, substance, or object connected with the accident or injury:						
What were you doing at the time of the accident or injury?						
Witness(es):						
Employee signature:				Date:		
Supervisor signature:				Date:		