



HUMAN RESOURCES & EMPLOYEE RELATIONS

**Supervisor's Report of Injury
Student Workers/Students in
Clinical Rotation**

Please Print

Student's Name: _____ Department: _____

Student's Title: _____ Date of Injury: ____ / ____ / ____

Time of Injury: _____ a.m. p.m. On premises? Yes ____ / No ____

Time student began work on the day of the accident? _____ a.m. p.m.

What is student's regular work schedule? (circle) M T W TH F Hours work per day? _____

Hours work per week? _____ Did supervisor witness the accident? Yes ____ / No ____

Name(s) of witnesses: _____

Location where accident occurred (if different than AVC, provide name of location & address): _____

Description of how accident occurred: _____

Part of body affected (i.e. back, left wrist, right eye, etc.)? _____

Did the student go to the doctor? Y / N Did an unsafe condition contribute to the accident: Y / N

Did the student commit an unsafe act? Y / N If yes, explain: _____

How could the accident have been prevented? _____

Supervisor: _____

Date: ____ / ____ / ____

Title: _____

