# ALBANY STATE UNIVERSITY

## Employee's Report of Injury

TO BE COMPLETED BY THE EMPLOYEE ONLY.

NAME OF INJURED: _____ Male: _____ Female: _____

Date of Birth / / Home Phone: ( ) _____

Home Address: _____ City/State/Zip: _____

Ram ID# or Last Four Digits of Social Security Number: _____-_____-_____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____

LOCATION OF ACCIDENT: _____

_____

Describe full how accident occurred: (including events that occurred immediately before the accident: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Describe bodily injury sustained (be specific about body part(s) affected: _____

_____

_____

_____

_____

Recommendation on how to prevent this accident from recurring: _____

_____

_____

NAME OF SUPERVISOR: _____ PHONE NO. _____

When did you report the accident to your supervisor? _____

To whom did you report the injury? _____

Do you require medical attention? Yes _____ No _____ Maybe _____

Name of treating physician: _____ Phone: _____

Signature of Employee: _____ DATE: _____

**Department of Administrative Services**
**Risk Management Services**
**200 Piedmont Avenue, S.E., Suite 1208 West Tower**
**Atlanta, Georgia 30334-9010**