Western Texas College Employee Injury Report

(form must be filled out and signed by the employee and supervisor at the time of injury)

Employee's Full Name **Last 4-digits of Social Security Number**

Employee's Street Address **City, State Zip**

Employee's Phone Number **Employee's Date of Birth**

Department of Employment **Date of Hire**

Location of Accident **Supervisor's Name**

Date of Injury **Time of Injury**

Describe in detail how the injury occurred:

What part of your body was injured? (please be specific)

Describe Injury :

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List Witnesses :

Will you be seeking medical treatment?

If yes, doctor or hospital name and location:

Date Lost time Began

I certify that the information contained in this report is true and correct.
I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.
I hereby authorize the release of all medical records related to the above noted incident to my employer, his agent or insurance company.

Employee's Signature **Employee's Printed Name** **Date**

I certify that the above employee has acknowledged to me that he/she understood all questions, signed and dated this form in my presence on this date.

Supervisor's/Witness' Signature **Supervisor's/Witness' Printed Name** **Date**