CLEAR FORM

Employee's Report of Injury

(to be completed by employee only)

Employee's Name _____ ☐ Male ☐ Female Date _____

Last *First* *Middle*

Date of Birth _____ Home Telephone Number _____

Home Address _____ City _____ State _____ Zip Code _____

Job Title _____ Length of Employment _____

Location of Accident _____

Address /Building/Room # *Area: (loading dock, rest room, classroom, etc.)*

Date of Accident _____ Time of Accident _____ ☐ AM. ☐ PM.

Describe fully how accident occurred: (including events that occurred immediately after the accident)

Details: _____

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

Details: _____

Recommendation on how to prevent this accident from recurring:

Details: _____

Name of Supervisor _____ Phone Number _____

Name of Witness(es) _____ Phone Number(s) _____

When did you report the accident to your supervisor ? _____

If not your supervisor, to whom did you report the accident/injury to? _____

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

Name of your treating physician _____ Date _____

Signature of Employee _____ Date _____

Middle Georgia State University

Submit the document to benefits@mga.edu

Updated 8/17/23