Andrews University

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Personal Injury Report

To be completed by the injured person.

Information about you

Your name _____ Daytime phone _____ Date of Birth _____
Home address _____
Your employer _____ Your occupation _____

Information about the accident

1. Was the accident job related? _____ If yes, please see your employer about worker's compensation benefits.
2. Where did the accident occur (be as specific as you can) _____
3. What was the date and time that the accident occurred? _____
4. What was the nature of your injury? _____
5. Please describe what happened. _____
   _____
   _____
   _____
6. What were you doing when the accident happened? _____
7. What were the weather conditions when the accident occurred? _____
8. Did anybody see the accident happen? _____ If so, provide their names and phone numbers.
   Name _____ Phone _____
   Name _____ Phone _____
   Name _____ Phone _____

Follow-up information

1. Did you receive medical treatment? ____ If so, on what date(s)? _____ Who was the medical provider? _____
2. As of today (the date you are completing this form), do you still have any symptoms related to this accident? If so, please describe them. _____
   _____

Your signature _____ Date _____

For office use

RHH notified (date)	
Investigation requested (date)	
Notes	