ANTELOPE VALLEY COLLEGE

Office of Human Resources & Employee Relations

Please check one:
[ ] Administrator
[ ] Faculty F/T
[ ] Faculty P/T
[ ] Classified
[ ] CMS
[ ] Registered Volunteer

EMPLOYEE STATEMENT OF ACCIDENT

Please Print

Employee Name: _____ Date of Birth:____/__/____

Address: _____ Phone #: ( )_____-_____

City: _____ State:_____ Zip:_____ Date of Hire:___/__/____

District extension:_____ Date of Accident: __/__/__ Time of Accident:_____ a.m. p.m.

Job Title:_____ Department:_____

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

_____

Witness(es) to the accident? Yes____ No___ if yes, name(s)_____

Description of how accident occurred:_____

_____

_____

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

_____

Pre-designated physician on file in HR? Yes____ No____

Name, address, and phone number of pre-designated physician?_____

_____

Tme you began work on the day of the accident?_____ a.m. p.m.

What is your regular work schedule? (circle) M T W TH F Hours work per day:_____

Hours work per week:_____ Social Security #:_____

Did you miss at least one full day of work after the injury? Yes_____ No_____

Date last worked?____/__/_____ Date returned to work? ____/__/_____

Still off work? Yes_____ No_____

Name of your immediate supervisor: _____

How could the accident have been prevented?_____

Employee signature: _____ Date:____/__/____

Additional comments: