## **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:	<del>-</del>	
DATE OF ACCIDENT:	TIME OF ACCIDENT:	
LOCATION OF ACCIDENT:		
Describe full how accident occurred: (including events that o	occurred immediately before the accident: _	
Describe bodily injury sustained (be specific about body part	(s) affected:	
Recommendation on how to prevent this accident from recur	rring:	
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	o Maybe	<u> </u>
Name of treating physician:		Phone:
Signature of Employee:		DATE:

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