

**SOUTHSIDE VIRGINIA COMMUNITY COLLEGE**

**Accident Report**

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Injured Employee: \_\_\_\_\_ Injured Employee's Position: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Injury \_\_\_\_\_  AM  PM

Campus/Work Site Where Accident Occurred: \_\_\_\_\_

Your reason for completing this report:  Injured Employee  Witness to Accident  
 Accident reported to you as Supervisor; Date Reported \_\_\_\_\_

Body Part and Nature of Injury \_\_\_\_\_

Specific Location of Accident (Bldg., Rm., etc.) \_\_\_\_\_

Outside  Inside  Wet  Dry On Employer's Premises:  Yes  No

In a Concise Paragraph, Describe How the Accident Occurred As Witnessed By or Reported to You:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WITNESS(ES) Enter the names of individuals who witnessed the accident \*\*  
(\*If not a SVCC employee, please note status ex. Student , visitor etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PREPARED BY: \_\_\_\_\_  
(signature)

TITLE: \_\_\_\_\_

\_\_\_\_\_  
(name printed)

DATE: \_\_\_\_\_

Upon completion, please send this form to Human Resources for submission to Workmen's Compensation Carrier.