

# ASU EMPLOYEE'S ACCIDENT REPORT FORM

**NOTE: To preserve your rights under the law you must give or cause to be given to the University a written notice of the accident. This notice is to be given immediately upon the occurrence of the accident or preferably within 24 hours. Return this form to Supervisor immediately upon completion.**

I hereby provide notice that I, \_\_\_\_\_, was injured or contracted  
(Please print name)

an occupational disease on \_\_\_\_\_ at \_\_\_\_\_ (am) (pm).  
(Date of accident) (Time of accident)

The location of the accident: \_\_\_\_\_

The nature of injury: \_\_\_\_\_

The part of body injured: \_\_\_\_\_

The injury or occupational disease was caused by (detailed description): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Employment Status:  Full Time  Part-Time  Temporary

Occupation when Injured: \_\_\_\_\_

Time you began work on day of injury: \_\_\_\_\_  AM  PM

Normal working days, (Please circle): Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Marital Status:  Married  Separated  Unmarried # Dependants Under Age 18: \_\_\_\_\_

**PENALTY FOR FRAUD**

**NOTE: WORKER'S COMPENSATION ACT, ARTICLE 1., SECTION 97-88.2.:**

- (a) Any person who willfully makes a false statement or representation of a material fact for the purpose of obtaining or denying any benefit or payment, or assisting another to obtain or deny any benefit or payment under this Article, shall be guilty of a Class 1 misdemeanor if the amount at issue is less than one thousand dollars (\$1,000). Violation of this section
- (b) is a Class H felony if the amount at issue is one thousand dollars (\$1,000) or more. The court may order restitution.

**BY MY SIGNATURE, I CERTIFY THAT ALL THE ABOVE STATEMENTS ARE TRUE AND ACCURATE AND THAT I HAVE READ AND UNDERSTAND THE ABOVE ARTICLE.**

**IF INJURY OR ILLNESS RESULTS IN LOST TIME FROM WORK, PLEASE CONTACT THE WORKERS' COMP ADMINISTRATOR IMMEDIATELY.**

\_\_\_\_\_  
Signature of Injured Employee Date Home Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_