Employee Accident/Incident Report
Southeastern Louisiana University
Human Resource Office

SLU 10799 Hammond, Louisiana 70402    - Faculty Box 10799 - Room # 106   - North Campus- Bldg. D

Each employee accident/incident must be reported on Human Resources Office Form No. 118 in order for the University to establish responsibility for insurance coverage with the Division of Administration. It is the responsibility of the supervisor to complete Human Resources Office Form No. 118, ORM Loss Prevention Form and the Medical Authorization Form in the following manner:

A. As soon as the supervisor is notified of an accident/incident the Accident/Incident Report, H. R. Form No. 118 and the ORM Loss Prevention Form should be completed and signed by the employee and their supervisor. The Medical Authorization Form should also be completed by the employee. Forms are also available in the Human Resources Office, North Campus- Building D.

B. If the employee goes to a physician, the employee should obtain the Authorization for Initial/ Emergency Medical Treatment Form from the Human Resources Office before going to the physician, hospital, etc. Once the employee has returned from the physician, the Original Employee Accident/ Incident Report form, the Medical Authorization, discharge instructions, etc. are turned into the Human Resources Office.

C. If the employee does not see a physician, the Employee Accident/ Incident Report and the ORM Loss Prevention form are turned into the Human Resources Office as soon as possible.

D. All charges for physicians, hospitals, prescriptions, etc. must be carried in the employee's name. Claims for reimbursement or payment of any charges may be forwarded to the Human Resource Office for transmittal to the Division of Administration, Office of Risk Management.

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**Dates/General Information**

Date of Report __________________________ Date and Time of Accident/Incident __________________________

Name of Person Accident Reported to __________________________ Time Reported __________________________

Normal Starting Time Day of Accident ___________ If employee back to work give date ___________

Date Employer Knew of Injury ___________________________ Date lost time began __________________________

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**Employee Information**

Employee Name ___________________________________________ Male/Female __________________________

Address ____________________________________________ Employee Home Phone # (_____) __________

Employee ID Number ____________________________ Budget Unit Name/ Number __________________________

Supervisor's Name (please print) __________________________ Work Phone# (____) __________________________
Parish of Residence ________________________ Race __________________ Marital Status ___________________

Number of Children under 18 ______________  Date of Hire _____________________ No. Yrs Service __________

Present Age _______________________________________ Date of Birth __________________________________

Department or Section Regularly Employed

Place of Injury -(Employer's Premises)  □ Yes  or  □ No

Occurrence

Exact Location Where Accident Occurred

What was employee doing when injured? (Be specific - if using tools or equipment or handling material-name them and tell what you were doing with them)

________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________

How did Injury Occur? (Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substance involved and tell how they were involved. Give full details on all factors which led or contributed to injury or disease.)

________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________

Name and work phone numbers of all witnesses

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Did Injury or Disease Occur Because of:  Mechanical defect:  □ Yes  □ No - Unsafe Act:  □ Yes  □ No

If yes, explain _____________________________________________________________________________

Nature and Location on Injury or Disease  (Describe Fully, include Parts of Body Affected)

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Did employee see physician, hospital, etc.?  □ Yes  or  □ No

Attending Physician and Address (If Hospital involved, please indicate)

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Date                         Employee's Signature                          Date  Supervisor's Signature