KEAN UNIVERSITY

Supplemental Report of Accidental Injury

Section A: Employee Certification *(To be completed by the Employee Reporting an On-The-Job Injury)*

Employee Name: _____ Accident Date: _____
Department: _____ Supervisor: _____

1. When was the date and time you reported the injury to your supervisor? _____
2. What is your regular work schedule (list the days and hours you normally work excluding overtime)? _____
   _____
3. Did the injury occur during a lunch or other break period? □Yes □No
4. Describe the work area at the time of the injury (location, equipment used, condition of area):
   _____
   _____
   _____
5. Describe how the injury occurred. What activity were you engaged in at the time? Why were you engaged in this activity?
   _____
   _____
   _____
6. Were there any witnesses to the injury/accident? If so, please provide their names and contact information, if available.
   _____
   _____
7. What tools or equipment were being used (check all that apply) □ N/A
   - □ Power tools (specify) _____
   - □ Hand held tools (specify) _____
   - □ Equipment (specify) _____
8. What Personal Protective Equipment (PPE) was being used? (check all that apply) □ N/A
   □ Eye protection □ Gloves □ Steel-toed shoes □ Others (specify) _____
9. What Procedures were being used? (check all that apply) □ N/A
   □ Lockout/Tagout □ Confined space □ Hot work □ Others (specify) _____

I, _____, certify that this injury/illness is not related to a pre-existing condition and that the aforementioned information is accurate. Furthermore, I understand that in cases where there is reason to believe that there have been omissions or misstatements of fact, the University or its designee may investigate. If the University concludes that there has been an abuse, disciplinary action, up to and including termination, may be taken.

_____ _____
Employee Signature Date

Section B: Supervisor's Certification

10. Do you agree with injured employee's account of the accident and all the statements s/he has made above? □Yes □No
If no, why not?

_____
_____
_____

11. Did you have an opportunity to observe the employee prior to the injury? □Yes □No

12. If so, did the employee show visible signs of a previous injury? □Yes □No
If yes, please describe.

_____
_____
_____

13. Did you witness the injury? □Yes □No

14. If there were any witnesses to the injury/accident, what was the witness's account of the accident?

_____
_____
_____

15. What corrective measures will be implemented to prevent recurrence and by what date will corrective measures be implemented?

_____
_____
_____

16. Have you shared corrective measures with other employees/units? □Yes □No
If yes, who? If no, why not?

_____
_____
_____

_____ _____
Name of Supervisor/Director Title

_____ _____
Supervisor/Director Signature Date