ACCIDENT REPORTING FORM

Williams College, 100 Spring Street, Williamstown, MA 01267

EMPLOYEE

1. Employee Name (Last, First, MI)		2. Home Telephone	3. Department
4. Home Address (No. & Street, City, State, Zip Code)		5. Marital Status ☐ Single ☐ Married	6. No. of Dependents
7. Date of Hire (MM/DD/YY):	8. Date of Birth (MM/DD/YY):	9. Sex ☐ Male ☐ Female	10. Hourly Wage $
11. Piece or Hourly Worker? ☒ Hourly	12. Hours Worked Per Day	13. Days Worked Per Week	14. Avg. 52-Week Wage: $ ☐ Estimated or ☐ Actual

EMPLOYER

15. Employer Name Williams College	16. Employer Self-Insured? ☒ Yes ☐ No	17. Federal Tax ID 04-2104847
18. Employer Address (No. & Street, City, State, Zip Code) 100 Spring Street Williamstown, Massachusetts 01267	19. Employer Telephone 413-597-4355	20. Industry Code 82
21. Insurance Carrier: Name and Address of Branch Responsible for This Case (Not Local Agent or Adjuster) **USI Insurance Solutions LLC** **123 Interstate Drive, West Springfield, MA 01089** **Phone Toll Free: 855-874-0123 / FAX: 413-739-9330**		
22. Worker's Compensation Policy Number	23. OSHA Case File Number (if applicable)	

INJURY INFORMATION

24. Date of Injury (MM/DD/YY):	25. Time of Injury Hour_____ ☐ A.M. ☐ P.M.	26. Source of Injury (e.g., Machine, Tool, Substance, etc.)	
27. Address Where Injury Occurred (if differs from #18 above)		28. On Employer's Premises? ☐ Yes ☐ No	29. Employer Location Code
30. Regular Occupation		31. Regular Occupation When Injured? ☐ Yes ☐ No	
32. To Whom Was Injury Reported?			33. Date Reported (MM/DD/YY)
34. Nature of Injury(ies) (Contusion, Abrasion, Strain, Sprain, Burn, Fracture, Cut, etc.)			
35. Injured Body Part(s) Description (Specify by using Left/Right Arm, Left/Right Upper/Lower Leg, Upper/Lower Back, etc.)			
36. Did employee receive medical attention? ☐ Yes – Complete 37and/or 38 below ☐ No			
37. Treating Physician Name and Address			
38. Hospital Name and Address			
39. Describe How Injury Occurred (e.g., The employee was…..Struck by...., Fell from...., Exposed to...)			
40. If Employee Has Returned to Work, Date of Return (MM/DD/YY):		41. Returned to Regular Occupation? ☐ Yes ☐ No	

42. Employee's Name (Please Print or Type)	43. Employee's Title	
43. Employee's Signature		44. Date Prepared (MM/DD/YY):